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ABSTRACT

This booklet, second in a three-volume series, presents discussions of the roles of some of the professionals and agencies involved in child abuse and neglect case management. Areas covered include working with abusive parents, child protective service agencies, physicians and hospitals, the police, teachers, and the schools. The first chapter concerns the role of "workers" (social workers, public health nurses, lay therapists), their responsibilities in relation to the families they are attempting to treat. The needs of the parents, who may have been maltreated during childhood, are emphasized. Chapter 2 describes the philosophy, organization, case management and staff of the Child Protective services program in Hennepin County, Minnesota. In Chapter 3, the role of the physician in diagnosing cases of suspected maltreatment is outlined. Also included are examination and reporting procedures for physicians and other medical professionals. Chapter 4 describes in detail the Abused and Battered Child Unit of the Los Angeles Police Department. Some examples of school committees and programs concerned with maltreatment are described in Chapter 5, along with guidelines for teachers. (SB)

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Volume 2

The Roles and Responsibilities of Professionals

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CHILD ABUSE AND NEGLECT

The Problem and Its Management

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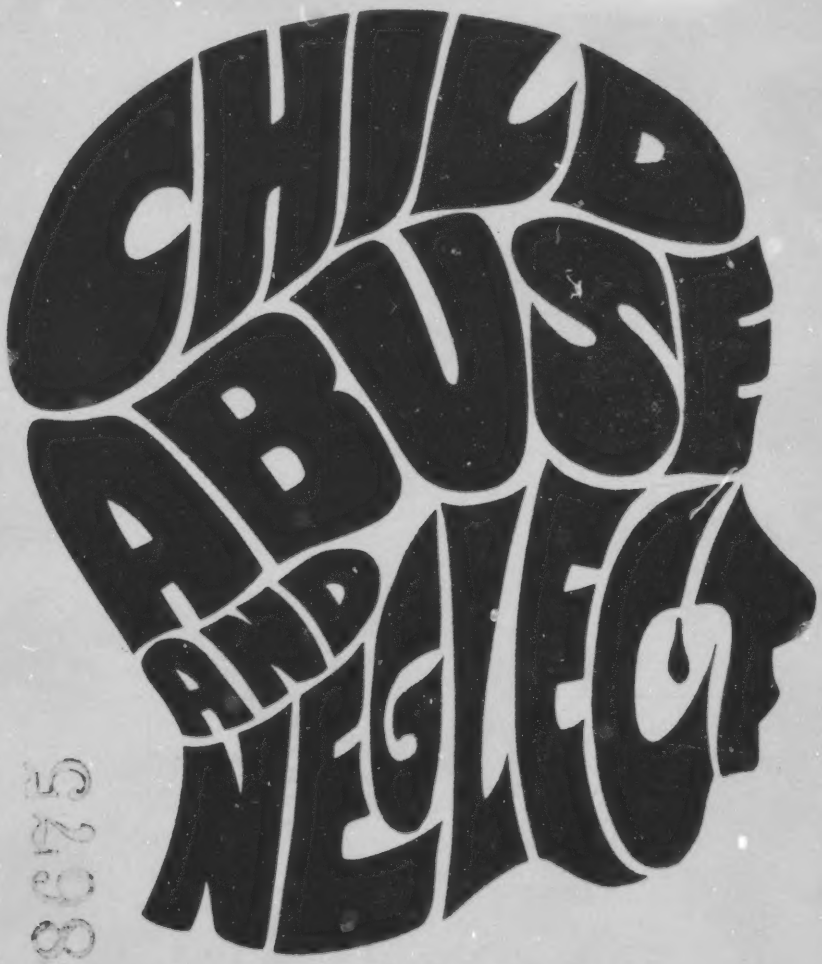
Volume 2

The Roles and Responsibilities of Professionals



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The Problem and Its Management

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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In preparing their materials for the series, many of the authors visited agencies throughout the country and interviewed various professionals in the field. Those whose ideas and opinions are expressed here are too numerous to list individually, although

each deserves a personal thanks for the interest and information provided. (To simplify reading, information obtained via personal communication is not specifically referenced; all unreferenced quotes and paraphrased comments included in any of these volumes are the products of personal interviews, conducted in 1974.)

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Foreword

On January 31, 1974, the Child Abuse Prevention and Treatment Act (P.L. 93-247) was signed into law. The act established for the first time within the federal government a National Center on Child Abuse and Neglect. Responsibility for the activities of the Center was assigned to the U. S. Department of Health, Education, and Welfare, which, in turn, placed the Center within the Children's Bureau of the Office of Child Development.

The Center will provide national leadership by conducting studies on abuse and neglect, awarding demonstration and research grants to seek new ways of preventing, identifying, and treating this nationwide problem, and by giving grants to states to enable them to increase and improve their child protective services.

One of the key elements of any successful program is public awareness and understanding, as well as the provision of clear and practical guidance and counsel to those working in the field. It is for this reason that the National Center on Child Abuse and Neglect is publishing a series of booklets—three comprehensive and related volumes (of which this is one), and three shorter booklets dealing with the diagnosis of child abuse and neglect from a medical perspective, working with abusive parents from a psychiatric viewpoint, and setting up a central registry.

While some material in all these publications deals with studies of specific local programs as opposed to generalized approaches, they are not intended to represent categorical or *functional* models upon which other programs should be based in order to be effective. Rather, they are intended to provoke thinking and consideration, offer suggestions, and stimulate ideas. Similarly, the views of the authors do not necessarily reflect the views of HEW.

In the present series, *Child Abuse and Neglect: The Problem*

and Its Management, Volume 1 presents an overview of the problem. It discusses child maltreatment from various perspectives, including characteristics of the parents and children, effects of abuse and neglect, a psychiatrist's view of the problem, and a discussion of state reporting laws. It also examines the many problems that make the abuse and neglect of children so difficult to comprehend and manage—from problems of definition and incidence to deficiencies within our system of child protection.

In Volume 2, the roles of some of the many professionals and agencies involved in case management are discussed: those working with abusive parents; child protective service agencies; physicians and hospitals; the police; and teachers and the schools.

Volume 3 presents a description of community coordination for managing and preventing child abuse and neglect. Within the context of the "community-team approach," various resources for identification and diagnosis, treatment, and education are discussed. The volume includes suggestions for developing a coordinated community program, examples of existing programs, and some current ideas on the prevention of child abuse and neglect.

This series of three volumes includes descriptions of many agencies and programs involved in managing the problem of child maltreatment. Again, each such description is intended as an example rather than as a model.

We hope that everyone concerned with detection, prevention, and treatment of child abuse and neglect will find some, if not all, of these publications of use in the vital work in which they are engaged. We hope, too, that these materials will be of use to those individuals and organizations wishing to become involved.

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We are not only
our brother's keeper,
we are also the keeper
of our brother's children.

— Fredric Wertham

A Sign for Cain:

An Exploration of Human Violence

Chapter 1
Working with Abusive Parents*

Introductory Notes

The terms "abusive," "battering," and "neglecting" serve as a shorthand way to describe parents who have been unable to protect or nurture their children adequately. The words draw attention to the problem and establish blame immediately; they are understandably offensive to the parents to whom they are applied, and to many who are trying to work with and help the parents and their children. "Abusive," "battering," and "neglecting" will be used selectively here. The word "parent" will be used without adjectives unless there is a need for clarification or emphasis.

"Workers," as used in this discussion, may be hospital or psychiatric social workers, public health nurses, social workers in private agencies, or lay therapists such as parent aides. They may also come from other disciplines or have other job identifications. But, for the most part, they will be protective service workers in public welfare agencies.

Finally, "child abuse" is used here to refer to physical, sexual, and emotional abuse and neglect. The feelings and behavior described as characteristic of parents who have abused their children are common to all people. In their extreme form, the characteristics are particularly applicable to the "abuser." In general, the milder the abuse, the milder the symptoms, and the less difficult the treatment. Parents who neglect, but do not physically abuse their children, are usually less difficult to see, but harder to help over the long term through the casework process. However, all generalizations have their exceptions; each parent is unique.

*Adapted from material written for the Office of Child Development by Elizabeth Davoren in 1974.

Those working with the problem of child abuse need to remain open-minded and flexible. There is much that remains to be learned and done, and there is much room for individual creativity on the part of workers.

* * *

Those working with the problem of abuse face the reality of violence against children. They are confronted with issues of parents' rights and children's rights and everyone's views on how to bring up a child. The first task of any worker, regardless of professional background, is to come to terms with his or her own attitudes and feelings.

It is emotionally disturbing to see a seriously injured or neglected child. We typically respond in one of two ways. We deny that the parents could be responsible for the child's condition, and search for some other explanation. Alternatively, if we do believe that the parent is at fault, we tend to feel righteously angry and disposed to criticize and punish the parent. Obviously, neither attitude is appropriate. Denial precludes any chance of dealing with the problem; the child remains without protection, and the parent remains without help. On the other hand, criticism and punishment have no real therapeutic value and are more than likely to have adverse effects on the family.

When the parent and child are viewed as a unit in need of help, rather than as wrongdoer and victim, the need for a therapeutic approach to the problem becomes obvious. This perspective can have a positive impact on all aspects of case management. For example, if people are aware that reports of suspected abuse or neglect result in help and appropriate treatment for the parents as well as treatment and protection for the child, they are then more likely to report. Reporting becomes a way of helping the family rather than a means of protecting children by "turning in" their parents.

The child is also safer when not made the adversary of the parents. The reality of criminal court trials and hearings is that their outcome may not result in child protection where needed. It is not uncommon for the child to be returned to the home where he or she has been abused and where the situation is essentially unchanged. In such cases, the risk to the child is probably greater than before.

This does not mean that law enforcement has no role in the management of child abuse. The reporting laws, the court system, and the police have all contributed to the protection of children. But it is important to differentiate between protecting children and criminally prosecuting their parents. Stated simply, it makes more sense to offer help and understanding to parents than to punish them for their problems in child-rearing.

Understanding why parents abuse their children is probably the most helpful factor in producing an understanding, non-punitive attitude in workers. Often, one is not working with an abusive or neglecting parent as much as with an adult who was maltreated as a child. This one basic premise is perhaps the most important organizing principle in understanding and working with the problem of abuse, regardless of the worker's professional training or type of approach. (See Chapter 2, Volume 1 for a discussion of the psychodynamics of abuse and neglect.)

Parents' Reactions to the Worker

Parents with the problem of child abuse tend to be isolated people who generally avoid contact with others. Since they typically have a poor opinion of themselves and distrust others, they find it hard to like and be liked. If reported for abuse, these parents are suddenly brought in touch with people to whom they can relate only with extreme difficulty. They are usually afraid that the workers will criticize or punish them. Even when parents recognize their need for help, they may fear and consequently try to avoid or discourage those who can help them. Their most common response is either acquiescence or hostility.

Acquiescence is reinforced by the parents' often extraordinary sensitivity to the expectations of others. Forced as children to anticipate and meet parental demands, these parents can be extremely skillful at saying what they are expected to say and doing what the situation requires. They conform as much as possible to the workers' expectations in order to get the workers "off their backs" and to end the interference in their lives. This "trying to please" response results in differing opinions about what abusive parents are "really" like, and leads workers to feel they know or understand a parent better than they actually do. Acquiescent be-

havior can also lead the unsuspecting worker into mistaking the parent's temporary conformity for permanent change.

Quite the opposite of the acquiescent parent are those who respond to workers with hostility, anger, and threats, particularly when told they are being or have been reported for child abuse. Their reactions generally result from their feeling accused, victimized, and interfered with in an area they regard as no one's business but their own—the raising of their children. In most cases, threatening parents are far less in control of the situation than they appear to be. Like acquiescence, hostility is a response to fear. Understanding and empathy are important in reducing the parents' fright and, in turn, their anger.

Workers can communicate their concern by focusing their attention on the parent: "What did your child do that upset you?" "Is your child hard to manage?" "Does your baby need too much attention?" "Is it difficult to get your child to do as you wish?" Such questioning can reassure parents that their feelings are important, while helping the worker obtain information about the parent-child relationship as well as the parents' needs for help.

Another way of relieving the parents' tension, particularly during the initial contacts, is to provide them with an accurate picture of what is going to happen to them. They should be told which people and services are available to help them. Offers of practical and specific help—in contacting family members, finding child care for other children in the family, providing transportation, or simply helping the parents think through the handling of such problems—may stimulate their willingness to accept treatment.

Helping the Parents

The kind of help abusive parents have responded to is more intense and personal than is usual in therapeutic relationships. It is sometimes called "reparenting" or nurturing. In practice, it involves meeting their many needs.

- The parents need help to feel good about themselves—to compensate for the devastating belittling they have experienced through their lives.

- They need to be comforted when they hurt, supported when they feel weak, and liked for their likable qualities.
- They need someone they can trust and lean on, who will be on time for appointments, will be there in times of crisis, and will put up with their crankiness and complaining.
- They need someone who will not be tricked into accepting their low sense of self-worth.
- They need someone who will not be exhausted with them when they find no pleasure in life, and when they defeat all attempts to help them experience pleasure.
- They need someone who can help them meet their practical needs, either by directing them to appropriate resources or by providing more direct help.
- They need someone who understands their difficulty in having dependents when they themselves have never been able to be dependent.
- They need someone who will not criticize them, even when they ask for criticism, and who will not tell them how to manage their lives.
- They need someone who will help them understand their children, without making them feel either called upon to understand what they cannot or stupid for not having already understood.
- They need someone who can give to them without making them feel inadequate for their need to be given to.
- They need someone who does not need to use them in any way.
- They need to feel valuable. Eventually, they need to be able to help themselves and to have some role in helping others.

Characteristics and Needs of Workers

Working with abusive parents is as demanding a job as the above list implies. It requires workers with exceptional sensitivity to others. Workers must be able to accept hostility and rejection without being devastated by it or needing to retaliate; they must

be able to feel at ease with parents' criticisms, yet not be critical of the parents' behavior; share themselves, without sharing their problems; befriend while being aware of their helping role; think first of the parents' needs, rather than their own; avoid using the parents to increase their own feelings of self-worth; and have a sense of personal worth and achievement that will sustain them through demanding work that offers few immediate rewards.

Even when workers feel strong within themselves and have fulfilling lives apart from their work, the nurturing of abusive parents can be exhausting. The parents' needs are great—at times, like bottomless pits. In drawing on their own emotional resources, workers are constantly aware of themselves, of their upbringing, and—if they are parents—of how they are raising their own children. The constant awareness can be draining. But what is most wearing is the knowledge that misjudging a parent's capacity to care for a child can result in the child's being seriously harmed or killed.

Workers need on-the-job support. Ways of providing such support vary from conventional supervision and staff meetings—where workers can discuss their cases and their feelings about cases and can seek case-management advice—to staff get-togethers where newer techniques of role playing, validation exercises, and facilitating are used to increase sensitivity and awareness and to allow group support of individual workers. As another means of giving support, some agencies limit the number of active child abuse cases per worker to perhaps one, two, or three, with less demanding cases rounding out the load.

Transferring cases from one worker or agency to another has led to workers losing track of cases; in some instances, the result has been a child's death. Several communities are using interagency committees or multidisciplinary teams to keep track of abuse cases and to provide workers with support in making decisions concerning diagnosis, treatment, and final disposition. (The multidisciplinary consultation team is discussed in Chapter 3.)

Supportive services—such as medical and psychiatric services, homemaking, emergency shelter care, crisis-intervention hotlines, day care, crisis nurseries, parents groups, emergency loans, and public health nurse visits—can not only help families directly, but

can relieve the worker from shouldering the total burden of a case. By bringing more people into the life of the family, supportive services help enrich the family's life with new contacts and experiences, and help diminish the needs that the primary worker must meet alone.

Homemakers, for instance, can be invaluable if they can cuddle the young and make them comfortable, while showing concern for the parents. Their work can amount to demonstration parenting; if done well, it gives the parents a sense of being cared for.

Day care personnel can be strong allies of the primary worker if they have the time, capacity, and know-how to help parents better understand their children. However, day care staffs sometimes tend to identify so strongly with the children that it is often difficult for them to understand the parents' needs, and even more difficult for them to help the parents. Sometimes, the most that can be expected is that the staff not compete with the parents for the child's loyalty, and that they not be threatened by the parents' inevitable complaints.

Emergency loans are a way to "put one's money where one's mouth is." Being able to arrange for loans, when needed to handle stressful situations, establishes the worker as someone who is sensitive to the "real" needs of the parents. It can also reinforce the parents' feelings of being nurtured, in a way no other service can.

Public health nurses can be responsible for supervising the children while the primary worker focuses attention on the parents. Health services are usually easier for the parents to accept. In fact, the public health nurse, if properly trained and supervised, can function as the primary worker in some child abuse cases.

These and other supportive services, discussed in Volume 3, can help both the family and the worker. Sharing the know-how of child abuse management among staff members of various community services—through seminars, training programs, and written material—can expand the list of facilities available to help

abused children and their parents, as well as those responsible for working with the families.

The Role of the Paraprofessional

Paraprofessional workers offer unique support to the primary worker. The worker's skill and time can be used for diagnosis and evaluation of the parents and for supervision and support of paraprofessional workers. A single worker can supervise many more cases than he or she could handle directly, while each family still receives individualized and competent care and treatment. It is essential, however, for the worker in this supervisory role to have experience in providing direct treatment to parents. In fact, continuing contact with parents is the best credential for those who would understand the problem of abuse and neglect well enough to direct the work of others.

When paraprofessionals are chosen for their similarity to the parent population—in age, race, nationality, religion, lifestyle, or whatever characteristics are relevant—their likeness can make it easier for a positive relationship to develop. The parents feel more in touch with the paraprofessional, and he or she feels more in touch with the parents. One of the most exciting potentials for paraprofessional worker assistance lies with the abusive parent who has had especially successful treatment. This parent is able to understand and reach out to other parents as no one else can.

Contact Begins

When the parents first contact is with hospital trauma workers or protective service workers trained to understand and handle cases of abuse, intervention has a more promising beginning. Special skills are needed to offer help to people who doubt that help exists or who believe they need no help. Even greater skill and self-assurance are required if the worker who reports the case or informs the parents of the report is also to provide treatment. Being able to stay with the parents through the reporting process and, when necessary, through court hearings can strengthen the therapeutic relationship.

There is an advantage in having one worker handle initial investigation and a second handle treatment: this allows parents

to focus their resentment outside the therapeutic relationship. But it can be disruptive to involve too many people too soon. Parents who are forced to see numerous professionals in the course of referral, and to repeat their story again and again, are likely to be difficult to reach with an offer of help. To take an extreme but not uncommon situation: parents may be seen first by the emergency room physician who has examined the child, then by a medical social worker who informs them that a report must be made, next by a policeman who responds to the report, then by a juvenile section police officer, a probation worker, and a protective service intake worker—before being assigned to the protective service caseworker who will continue to handle their case. Regardless of the sensitivity and understanding of these various professionals, few people have the emotional stamina to cope with this much "help."

The First Step in Treatment

In many cases, what parents need first is someone willing and able to make an effort to see them. Workers' ability to reach out to parents is an essential part of treatment. Home visits are not only useful in themselves, but may be the only way for workers to see the parents, at least initially. Patience and persistence are important. Some parents avoid involvement by disappearing when the worker is expected, by not answering the telephone or the door, or by focusing their attention on television during the worker's visit. The worker may have to return again and again, insisting on some sort of contact with the parents. As noted earlier, the worker's ability to offer specific and practical help can be a meaningful way to start.

Sympathetic, responsive, nonjudgmental listening can be invaluable. People who have never been listened to may at first doubt that anyone is interested in what they have to say. Parents often have to be convinced that talking is useful—obviously a difficult first step for a method of treatment that relies on talking as its main tool. Friendly chatting is an icebreaker.

Workers have to find their own ways of relating to parents; genuine, honest, forthright behavior is essential. These parents, with their special sensitivity, quickly spot pretense. When a parent feels threatened or angry or distrustful, feedback to

the worker may be hostile silence. The worker, in trying to be genuine, may be genuinely ill-at-ease and may not know what to say. It does not matter if words seem silly or inappropriate; the worker's desire to do right is what comes across to the parent. Showing honest respect for the parents and for their capabilities helps to put them at ease. And if the parents are to engage in a useful dialogue, they have to feel at ease with the worker.

Information given by parents early in the contact is often unreliable. One reason is that their own parents' misperceptions of them have caused them to be confused about themselves. In a sense, they misperceive themselves. Sometimes, when the parents do not trust their workers, they use inaccurate information as a protection against feared punishment. In other cases, the parents may simply say what they think they are expected to say. Often, when two workers are involved with the family, they are astonished by the quite different impression each has of the parents—based on the completely different stories the parents tell to each. As the parents develop trust, talking becomes more useful to both the parents and the worker, and information becomes more factual.

There is no orderly progression to treatment. Many areas have to be dealt with at once. For instance, exploring what the parents want for themselves and for their children can be more successful once the parents begin to trust. Yet exploration of what the parents want shows them that their opinions matter; and this, in turn, helps them to develop trust.

At first, the parents are not likely to know what they want for themselves, since they seldom believe they are capable of doing anything. Usually, they wish passively, with little hope, to have things done for them. If their children have been placed, they may say that they want the children returned regardless of their feelings about the placement. They may wish for a better place to live, or new clothes, or a vacation; but beneath these layers of wants and desires, others lie. For example:

- A mother of three children, who have been repeatedly injured and poorly cared for, had been raped at age 10 by her father. Years of promiscuity followed, then prostitu-

tion, procuring, and prison. What she actually wants is respectability. She wants to approve of herself.

- A mother of four had been adopted, and later totally rejected by her adoptive parents. She wants to be able to give up one of her children, toward whom she alternately feels murderous rages, apathy, and guilt; but she has to be sure that he will not be rejected by his adoptive parents.
- A brain-damaged mother of two had been abused by her own parents. She wants to be able to function as a reasonable, competent adult. Among other things, she wants to learn to read.
- A father of two children was brought up in an orphanage where he was beaten. He wants to feel more comfortable with others. He needs relationships with people who will understand his needs for dependence.
- A mother of three, brain damaged herself as a result of abuse as a child, injured one of her own children, causing a fractured skull. She wants to learn how to mother and bring up her child herself.
- A mother of two adopted children, whom she beats, was emotionally and physically deprived as a child. She wants to be a better mother and to eventually run a nursery school for unwanted children.
- A mother of two finds comfort in a life without children and would like to place her children for adoption.
- A mother of three, who was neglected and brought up in isolation, wants either to improve her marriage or to leave her husband.
- A woman who was raised by her grandmother because she was beaten and neglected by her mother, lost her first baby; child abuse was suspected. Her second child was injured shortly after birth. The woman does not want to care for children under age five; she wants to be alone with her husband and to have her mother care for her baby.

Parents can begin to think of their children's needs only when they begin to take their own needs seriously. Before they reach this point, however, they need some special care.

A Declaration of Dependence

Encouraging parents to depend on the worker is a key part of the reparenting process. But dependence sometimes frightens workers; they see themselves being used up, or fear having to take care of the parents' overwhelming needs forever. Some treatment approaches have even emphasized the importance of parental self-reliance. But abusive parents have typically had a lifetime of unsuccessful self-reliance. As children, many had to take care of themselves as well as the adults in their lives. Unless their old habits are broken, they can neither care for their children nor seek worthwhile self-gratification. Dependence allows parents to experience the nurturing that permits them to grow.

The more people involved in nurturing the parents, the better their progress will be. Parents who are together in groups can help each other greatly and can provide mutual support both within and outside the group. The parents tend to feel comfortable with one another and are more readily available to other group members. Parent groups can serve as an important adjunct to individual therapy or, for some parents, can serve as the primary treatment modality. But the most deeply troubled parents need help before they can join a group, and almost all the parents need individual attention in addition to group help.

The provision of concrete services is one way of helping to meet dependency needs. If community resources are unavailable or scarce, workers may be able to provide some services themselves. For instance, although chauffeuring is often considered nuisance work, highly productive interviews can take place in the casual atmosphere of the car.

Parents' self-esteem is increased by the caring process. The worker who can meet their needs lets them know that they are important. If it is impossible to provide services or if they are not needed, caring can be communicated in other, often simple ways. For instance, being on time for appointments—even when parents are late or do not show up themselves—tells the parents that they matter.

The Next Steps in Treatment

As the parents begin to feel worthwhile, as they begin to trust and depend on their workers, they tend to be more honest about their feelings and to feel more friendly toward their workers and others. At this time, the parents should be helped to find ways of including more people in their lives—if they have not already done so on their own.

They may also be able to do more for their children now, even though they may complain more about the children. It is important to remember that complaining is a way of releasing angry aggression—usually a much better way than what the parents have used in the past. Questioning parents about their children—what they expect of them, what they want for them, what changes they notice, what they enjoy about them, when they feel most perplexed about what to do with them—will give the worker many clues. When parents are ready to explore these questions, they are often ready to allow their children to become more dependent and to decrease their own demands on the children. They are also ready for their children to include more people in their lives. The children can be given attention and care, without the parents' feeling excluded or rejected.

At this stage, it can be useful to give parents specific information about child development and about what they can realistically expect of their children. However, this does not mean that parents should be told how to take care of their children. Workers must respect parents' ways of dealing with their children, although this is not always easy and in no way includes ignoring or accepting abusive behavior.

With support and acceptance, the parents' threshold of anger may be appreciably lowered. In turn, they may be less angry with their children. It is even more beneficial if aggression can be funneled into productive, pleasurable activity. Although workers cannot do this for the parents, they can direct parents to appropriate available resources.

* * *

Although the success of treatment will be judged by what ultimately happens to the abused child, the protection of that

child will depend on the well-being of his or her parents or caretakers. Misunderstanding or ignorance of the causes and nature of child abuse often lead to a desire to punish parents who have abused their children, particularly when the abuse is severe. But in a sense, punishing the parents means punishing the children as well.

The capacity of workers to deal with the problem of child abuse will depend on their individual strengths and on the professional and management support given to their efforts. But support to workers is sometimes compromised by "power struggles" among professionals involved in child abuse cases. Different perspectives on the problem lead to conflicting opinions both on the "right way" to handle cases and on the profession or group who should assume leadership in case management. The problem of child abuse will probably never be managed successfully without honest communication, cooperation, and coordination of activities among members of the social service, medical, and legal systems. Power struggles not only deplete needed energy, but can endanger the very children these systems profess to protect.

Chapter 2
Child Protective Services: Hennepin County, Minnesota*

Child protective services (CPS) originated in 1875 with the New York Society for the Prevention of Cruelty to Children. Although CPS agencies were initially law-enforcement oriented, with an authoritarian approach to cases of abuse and neglect, they have since developed positive, nonpunitive methods of protecting children and helping families in crisis. They function as representatives of society, attempting to fulfill the desire of the community that certain standards of parental behavior and certain basic needs of children are met.

According to standards set by the Child Welfare League of America, child protective services operate on a belief in:

- the dignity of the child as an individual, with both a right to adequate care and a stake in a continuing relationship with his or her parents
- the right of parents to fulfill their role in being responsible for their children, and to have available resources that will stimulate and strengthen their potentialities for parental functioning, or that will clearly determine that they are unable to give their children satisfactory care in their own home
- the desire of most parents to be good parents
- the assumption that parental neglect, abuse, and exploitation are more likely to be symptoms of severe personality disturbances, social deprivations, and unhappiness than willful, premeditated forms of behavior
- the capacity of most people to change

*Much of this chapter has been adapted from material written for the Office of Child Development in 1974 by William E. Howard.

- the responsibility of society for children, and the accountability of any agency providing protective services to the community that delegates specific responsibilities to it.[1]

Beginning in 1935, with the passage of the Social Security Act which authorized public child welfare, protective services have gradually been transferred from private to public auspices. Today, most county welfare departments do offer child protective services. But because of variations in state laws and in administrative policies, the nature and scope of protective services varies nationwide. Child protection is an evolving service, conditioned by the needs and desires of the community and by changing legal interpretations of children's and parents' rights.

Rather than presenting a general outline of standards, policies, and procedures of CPS units, this chapter describes the protective service program of the Hennepin County (Minnesota) Welfare Department. The Hennepin County program should not be considered a model that other communities can or should adopt. It was chosen for discussion because it is a countywide system known to be effective for its community.

Created in 1944, Hennepin County's CPS Unit is among the oldest public-supported services of its kind. It has been recognized by Vincent De Francis, director of the Children's Division of The American Humane Association, as one of the nation's outstanding child protective programs. The Unit serves Minneapolis and its suburbs—a metropolitan population of approximately one million people, of whom almost one-third are under 18 years of age.

Organization

Hennepin County's CPS Unit was created when the county welfare department assumed the responsibilities of the Community Chest supported Children's Protective Society in 1944. No one today is certain whether the establishment of a specialized unit came about by accident or design.

Under Minnesota law, the protection of children is not a voluntary service; the welfare department is required to intervene in the private affairs of a family upon receipt of a report of child

abuse or neglect. The investigation, disposition, and treatment of cases involves due process of law, the rules of evidence, and the protection of both children's and parents' rights.

From an organizational standpoint, Hennepin County welfare officials believe it is essential to fix responsibility for discharging the department's legal obligations. The proper way, they feel, is through a separate protective service unit. As one CPS official explains: "If you bring protective services into the general welfare program, as has been done in some places, it is too easy to pass the buck. Here, we are responsible." The creation of a separate unit has had an additional benefit: it has enabled CPS to develop a philosophy and specialized techniques that might have been impossible to develop in a general welfare program.

CPS operates within the welfare department's Family Services Division, and includes five subunits: an assessment subunit, for the screening of reports and the intake of cases; and four field subunits. One of the field subunits handles all cases of severe physical abuse; another is responsible for all sexual abuse cases. Cases of neglect and moderate physical abuse are distributed among the four.

CPS is currently staffed by 41 principal social workers, the highest-ranked professional practitioners in the department; five staff supervisors; and a program supervisor. The annual budget of approximately $3.4 million includes, in addition to salaries, funds for homemaker services and the foster care of children in the Unit's charge. In nearly all cases, CPS caseworkers consult with outside specialists—psychiatrists, doctors, nurses, and various types of therapists. The formation of multidisciplinary teams to deal with specific problems is dictated by the nature of the individual case and is handled informally.

Like all public protective service units, the Hennepin County Unit is crisis oriented—it deals with conditions of neglect and abuse that have already occurred. Its functon is primarily rehabilitative, and its approach is nonpunitive. The chief concern of CPS is to assist families to make changes that will facilitate the children's physical and emotional development. In this sense, the Unit feels it acts as a preventive force; its objective is to

prevent children from becoming parents who will abuse or neglect their own children.

Family Counseling, the other half of the Family Services Division, furnishes public-supported services from child care to mental health services—to families who request them. There are 19 Family Counseling units throughout the county. In addition to providing therapeutic services to families referred by CPS, these units also function as a preventive resource by attempting to identify and alleviate conditions that could lead to the abuse or neglect of children.

The Shaping of a Philosophy

When CPS was first established, it suffered what might be called an "identity crisis." In keeping with the decision to make child protection a separate function within the welfare department, the Unit was restricted to cases of neglect and abuse. However, this was an abrupt departure from the function of the Unit's predecessor, the Children's Protective Society, which had taken any kind of child-welfare case—the retarded, adoption placement, as well as cases of abuse and neglect. The society had taken a nonpunitive approach toward cases of child maltreatment but had made no attempt to treat the causes of family dysfunction. Its primary goal had been to prevent a child's situation from worsening by keeping a watchful eye on the family.

The community had been satisfied with the society, despite its limitations, and was displeased with the new concept of CPS. More criticism followed when the Unit set forth the conditions for applying its services: there must be a complaint of abuse or neglect; the family is not free to refuse the Unit's services; the Unit is not free to withdraw its services merely because the parents refuse or cannot use help; and if the parents are unable to improve the child's condition, the Unit is obliged to bring the case to the juvenile court.

When CPS applied these conditions, particularly the last, it was accused of prejudging cases and accepting only those that could be "won" in court. The Unit's rationale was that protective services required a new and different approach. CPS officials felt that the Children's Protective Society had accomplished little,

other than to act as a salve to the community's conscience. What the Unit wanted to do was provide meaningful protection and assistance for abused and neglected children.

In its first two years, CPS took a narrow view of the services it should provide. Its approach centered largely on the specific complaint of neglect or abuse. Caseworkers tried to get the parents to change their child-rearing patterns within a limited time period, but made no attempt to treat the causes of a family's problems. In cases where there was no apparent effort to improve conditions in the home, CPS relied heavily on the juvenile court to stimulate parental change. At this time, approximately 40 percent of its cases involved a court proceeding, and there was a growing number of placements in foster homes. As one supervisor recalls, "We acquired a reputation of being child-grabbers—with some justification."

When child maltreatment recurred in many families who had been served by the Unit, CPS changed its approach. There was, at the time, a growing realization that child maltreatment was only a symptom of much deeper family and parental dysfunction. Accordingly, CPS broadened the responsibilities of its caseworkers, giving them a supporting, clarifying, and enabling role. They were instructed to temper the use of their authority and to be compassionate, understanding, and respectful toward the parents—an attitude that is basic to the CPS program today.

In contrast to the Unit's former, rather punitive attitude toward reported parents, one of the agency's current dicta for caseworkers is that "parents love their children in their own unique way and fundamentally do not want to hurt their children." Consistent with the policy that the program be "family centered, but child focused," workers are reminded to "always focus on the welfare of the child, but [to] keep in mind the child first and foremost needs his own parents and his parents should be helped to care for him." The Unit adheres to the premise that children, once removed from their own homes, incur an irreparable emotional scar; even temporary foster placement can damage the security of the permanence they felt in their homes.

According to one CPS official, "Our goal is to accomplish the rehabilitation of a family on a voluntary counseling basis."

If removal of the child is indicated, the Unit encourages the parents to agree to a temporary placement. Only if they refuse are they taken to juvenile court.

In recent years, only 10 to 15 percent of the CPS caseload has involved court action. One reason for the reduced court involvement is that caseworkers have had a fair degree of success in persuading parents to place their children with relatives. Use of the extended family carries a double benefit. It has helped reduce the welfare department's expenditures for foster care, currently $40 per day for each child in a residential treatment center. More important, as a supervisor notes: "It lets children be with people they know and can relate to. A relative's home is much less frightening for a child than a strange foster home."

Since its inception, CPS has made various improvements in its treatment techniques and has helped focus community services on the welfare of children. Currently, for example, the Unit is cooperating with school social workers to identify families at risk for child abuse or neglect and to refer them to appropriate community resources in order to prevent maltreatment from occurring. As another example, CPS has arranged for special education at home for children with learning handicaps.

It is, of course, difficult to measure effectiveness in the field of child protection. But CPS officials believe the Unit's philosophy has worked. As one indication, the recidivism rate between 1963 and 1973 averaged less than 9 percent in cases of physical abuse and 17 percent in cases of neglect.

Identifying Abuse and Neglect

As in most agencies of its kind, the majority of cases referred to CPS involve general neglect. In 1973, for example, the Unit provided services to 145 children who had been physically abused, 23 who had been sexually abused, and 693 who had been subjected to some form of neglect. These totals include 387 carry-over cases and 474 cases opened during the year.

Over the years, the Unit has developed explicit criteria for identifying conditions of abuse and neglect. It defines as abuse: "Any case in which the child exhibits evidence of bruises and

welts, burns and scalding, abrasions and lacerations, wounds, cuts, bites and punctures, malnutrition, bone fractures, subdural hematoma, soft-tissue swelling, failure to thrive, concussions, or death, when such conditions or death are not justifiably explained; or where the history given concerning such conditions or death, or circumstances indicate that such conditions or death may not be the product of an accidental occurrence."

Minnesota law contains a comprehensive definition of neglect, including abandonment; lack of proper parental care; and lack of necessary subsistence, education, or other care needed for the child's physical or mental health or morale. For casework purposes, CPS has expanded the legal definition, grouping conditions of neglect into four categories and listing them in detail. In brief, these conditions are:

- physical neglect, which includes physical and sexual abuse, exploitation, malnutrition, lack of medical care, lack of supervision, and abandonment
- emotional neglect, which includes denial of "normal experiences that produce feelings of being loved, wanted, secure, and worthy"; rejection; and such possible symptoms as hyperactivity, withdrawal, firesetting, suicide attempts, failure to thrive, delinquency, discipline problems, and others
- material neglect, including insufficient and improper clothing, inadequate shelter, and insufficient food
- demoralizing circumstances, such as continuous friction in the home, mentally ill or immature parents, excessive drinking or drug abuse by parents, exposure to a criminal environment, or encouragement of delinquencies.

Although well established in the community, the Unit encourages its staff members to appear before professional and public groups to discuss the CPS program and society's responsibility to identify child abuse and neglect. In hospitals and schools, for example, caseworkers conduct informal briefings for the staffs on the diagnosis and reporting of maltreatment. They stress that, although Minnesota law requires only medical personnel to report suspected abuse, others are encouraged to "speak for the child who cannot speak for himself."

CPS officials consider the cooperation of the staffs of city schools and the larger hospitals to be generally good. But they note that both teachers and doctors in some of the more affluent suburbs are reluctant to report, even though the law provides immunity for such reporters. Teachers are apparently afraid of reprisals if they report a child from a socially prominent family, and family doctors appear to defer to the parents' rights to discipline their children as they see fit. For instance, when asked why he had not reported a case in which a suburban father broke his teenage daughter's jaw, the attending physician replied that the girl "had it coming to her."*

A CPS supervisor notes some of the consequences of uneven reporting by urban vs. suburban professionals: "We don't know precisely how prevalent child abuse is in the suburbs, but we suspect the rate there is no different from anyplace else. Because the poor are subjected to greater scrutiny by public agencies, we find that 72 percent of all our abuse cases are public-assistance oriented. What this means to me is that the poor kid has protection but the wealthy kid doesn't."

Case Management

Intake and Assessment. The provision of protective services generally begins with a telephone call. Most reports to CPS are made via the countywide reporting line.** Neighbors, friends, and relatives are the main sources of reports of neglect, moderate physical abuse, and sexual abuse. When a child has been severely injured or abandoned, the report usually comes from a hospital, school, day care center, or the police.

Except in suspected cases of severe physical abuse, which are immediately referred to one of the field subunits for investigation, all calls are logged and screened by the assessment subunit, which is staffed by six workers and a supervisor. Even though many involve borderline cases or appear to be vindictive acts

*Under Minnesota law, medical personnel who fail to report suspected abuse are guilty of a misdemeanor. However, in Hennepin County, this provision of the law has never been tested.

**After regular office hours, the line is answered by the welfare department's Emergency Social Services Unit. CPS supervisors are contacted if immediate action is needed to protect a child.

by hostile relatives or neighbors, all reports are carefully investigated by assessment workers.

The worker interviews the reporter at length to learn as much as possible about the nature of the report and the condition of the child. If the report involves an apparently serious case, the reporter may be asked to sign a statement or to appear as a witness if needed. As a rule, the assessment worker tries to validate each report by checking three or four sources, including the Unit's computerized list of current and past cases, and the child's teachers and school social worker if the child is of school age.

All available information is then compiled in summary form in a case record, and the case is personally investigated by a field caseworker. Less than half the reports received by CPS each year reach this stage of requiring personal investigation. Fifty-five percent of those that are investigated by field units are found to be borderline or invalid; the field caseworker, for example, may find that the family is already taking adequate steps to remedy the situation. In some 10 percent of the field-investigated cases, the parents are referred to Family Counseling.

Treatment: Neglect. The field investigation of reports of neglect and moderate physical abuse is initially much the same. The caseworker visits the home and explains to the parents that CPS has received a report "from the community"* concerning the care and treatment their children are receiving, and that the Unit is obliged to evaluate the situation in the home.

Caseworkers treat information provided by neighbors and relatives as allegations rather than facts. But the reported information does prompt questions: What is your family life like? How are you and your children getting along? What do you see as basic problems of your family? As a staff supervisor explains: "When we come on in this nonaccusatory manner, we more often than not get a much clearer picture of what the core problems of the family are, rather than what they appear to be to outsiders. We learn what people are experiencing themselves."

In cases of neglect, the families are generally suffering from a

*Reporters are not identified.

combination of problems. The caseworker tries to order these as a basis for developing a family treatment plan, then counsels the parents and coordinates their needs with available community resources. In some families, for example, where the parents are unable to manage the money they have, a home management aid worker may be brought in to teach the parents how to develop a budget, how to get more food and clothing for the dollar, and how to supervise the household. Such practical counseling is frequently a key to bringing about constructive change in a family's life style. Depending on the nature of the problem, caseworkers may refer the family to such resources as Alcoholics Anonymous, day care centers, mental health clinics, the state's division of vocational rehabilitation, special adult-education programs, tutors for the children, or summer camps.

In more serious cases of neglect, the caseworker usually develops with the parents a set of goals that are both realistic and attainable. Sometimes, in order to protect the children and help the parents attain the goals, the caseworker will ask the parents to agree to temporary placement of the children. If they do not voluntarily agree, the case must be taken to juvenile court. In these cases, the return of the children in placement would be timed to actual changes made by the parents. The judge reviews the goals and the timetable, and requests periodic progress reports prepared by the caseworker in consultation with the family.

Neglect cases tend to remain active on the average of one year, although many families—including those in which children are in foster care—require assistance for a much longer time. At the end of 1973, CPS was maintaining more than 400 children in alternate-care facilities—more than half in foster homes, the others in receiving shelters, group homes, and residential treatment centers. Caseworkers are responsible for children in foster care until the case is closed. One caseworker noted the difficulties in rehabilitating families: "Problems usually remain when cases are closed. A lot of changes are made, but they are not always permanent."

Treatment: Physical Abuse. CPS applies three classifications to physical abuse: cases of repeated trauma are classified as *battered*

child syndrome; one-time abuse as *physical abuse—severe;* and repeated bruising as *physical abuse—moderate.* Treatment varies with the severity of the abuse.

Both the battered child syndrome and cases of severe physical abuse are relatively infrequent in Hennepin County, accounting for about 17 percent of the 145 reports of physical abuse in 1973. In such cases, the Unit's first concern is to ensure the child's safety. The initial emphasis is on speed. Unless the child has already been admitted to a hospital, the police are called at once to make an emergency removal to a hospital or temporary shelter; and a field caseworker goes immediately to the facility where the child is being held.

As a rule, caseworkers obtain a "hold" order from the juvenile court to prevent the parents from removing the child from the hospital or children's shelter. The court requires a hearing on such orders within 72 hours; otherwise, the parent can regain custody of the child.

Caseworkers have learned that it is best to become involved with the parents early—at the time the child is first removed. At that moment, they may agree to institute changes in their lives that they might not accept three or four days later. During the "hold" period, for example, the caseworker may seek the parents' agreement to voluntary foster placement of the child and psychiatric care for themselves.

As one staff supervisor explains the casework approach: "We try to make the parents realize that they are no different from other people, that everybody gets frustrated and angry at times, and that everybody is a potential child abuser. This isn't to say we condone abusive behavior; rather, we try to help the parents understand that they're not alone. If they can accept this approach, the parents themselves can often become the best resource for protecting the child from further abuse."

If the parent is charged with assault, the court may order a psychiatric examination. CPS caseworkers work with the psychiatrists, but do not attempt their own form of counseling until the parent returns to a more stable mental state.

Cases of moderate physical abuse are handled somewhat differently. If, for example, a child is reported as coming to school each Monday with bruises on his or her face, and if the case is assessed as moderate physical abuse, a field worker may inform the parents of the report via a telephone call or a letter. Parents usually find out that they are being investigated and are subject to guilt and fear of punishment. CPS prefers to let the parents know of the allegations before the caseworker's visit. Normally, by the time the caseworker appears in person, the parents are more willing to discuss their problems and possible solutions.

Some parents, however, are adamant in their refusal to deal with CPS. In these cases, the field worker informs them that the Unit has no alternative but to involve the juvenile court, and that court action could result in foster placement of the child. In 1973, CPS had to carry through on this threat in only eight percent of its physical abuse cases.

Cases of physical abuse remain active in CPS an average of six months. A supervisor notes that this depends largely on how soon the parents can be persuaded to act positively on their problems: "We try for a quick turnaround to keep the number of cases in balance with our staff. But we don't make a conscious effort to wrap up cases in six months. We take all the time that's necessary." A caseworker, for example, may see the parents from one to four times a week in an intense effort to get them to seek help voluntarily. When they agree to treatment, the case is transferred to the welfare department's Family Counseling section.

Treatment: Sexual Abuse. The CPS approach to sexual abuse cases is different from that to cases of neglect or physical abuse. Part of the reason is that sexual abuse creates a much stronger reaction from the community—particularly from the police and the county attorney's office. Sexual abuse is difficult to prove; but when law enforcement officers do obtain evidence, they usually want to prosecute the abuser. This often places CPS caseworkers at odds with the police and prosecuting attorneys. The Unit tries to keep cases out of criminal court in order to protect the child from being further traumatized by having to testify against the abuser.

CPS defines sexual abuse as any sexual liberties taken by an

adult with a child and incest as actual sexual intercourse, either genital or oral, with a blood relative. In general, the handling of incest cases differs from that of sexual abuse involving an adult not related to the child.

Incestuous relationships are usually maintained for some time before they are reported. They generally begin when the child (usually a girl) is seven or eight years old, and progress until she is old enough to question the relationship or becomes afraid of pregnancy.

With a case of incest involving an adolescent girl, CPS takes an aggressive approach. The Unit will try to get the father to move from the home voluntarily; if he refuses, a criminal charge will be brought against him.

With cases involving preadolescent girls, the casework approach is nonaccusatory. As a supervisor explains: "We talk to the father, telling him what has come to our attention, but we don't ask him to admit or deny it. If accused, the father will often deny the relationship. We're very firm that we want to talk to his daughter. Afterward, we talk to him again. So much of it is the style of the workers—how they handle themselves rather than what they say."

Some men are so relieved to be discovered that they make a full confession. In these instances, the caseworker informs the man that the caseworker-client relationship is not privileged, and that the worker may have to testify against him if the case should be taken to court. In other cases, the man will claim that his daughter misinterpreted his actions, but will then voluntarily move from the home. The caseworker then focuses on the child to assess her emotional state and her need for further assistance. Both mother and daughter may require extensive counseling. Frequently, the girl will need help in handling guilt feelings if her father is jailed, or in dealing with her mother who may be angered at losing her mate.

CPS has had some success in getting fathers to agree to treatment and in rehabilitating them in the home. In general, once the man admits the offense and obtains psychiatric help, he does

not resume the incestuous relationship. There is greater danger of recurrence if he maintains his innocence.

Nonincestuous sexual abuse most commonly involves a girl 10 to 15 years old and her stepfather or her mother's lover. Often, the man has a history of taking an interest in young girls. He is dominant and may use force on the girl. In some cases, the mother is aware of the situation but refuses to protect her daughter for fear of losing the man. There have been instances where the mother punished and blamed the girl for seducing the man.

According to one CPS supervisor: "In these cases, we direct ourselves to the mother first, and then to the girl. We tell the mother she has legal responsibilities to her daughter, and try to get the mother and daughter to go to the police and make a statement. The girls are often anxious to make such statements in order to clear themselves."

The caseworker, however, tries to keep the girl out of court. A defense attorney would most likely attempt to prove that she was sexually provocative and would subject her to a humiliating cross-examination. To resolve the situation, the caseworker often asks the mother to bar the man from the house. The Unit will loan her money or provide other housing should she and her daughter have to move from their home. If the mother refuses to cooperate, the caseworker may have to file a petition in juvenile court to obtain custody of the child.

Staff

Because of the various specialized duties CPS caseworkers must perform, the Unit's policy is to hire only mature and experienced practitioners. One CPS official notes: "We've been accused of elitism because we are very selective about who we bring on the protective service staff. But this is an extremely demanding program, and it takes an exceptional person to do this work. That applies to both our caseworkers and their immediate supervisors."

To qualify for a caseworker position, an applicant must have a master's degree in social work and at least one year of paid, full-time, social work experience; alternately, he or she must have a

bachelor's degree and three years of paid, full-time, social work experience.

In addition to these minimum requirements, candidates are expected to possess certain knowledge and abilities. For example, they are expected to have knowledge of current principles and practices of social work regarding the treatment of major behavior problems; the causative factors in social maladjustment; physical and mental illnesses and their impact on personality and behavior; the principles of community organization; general social legislation and the child welfare laws; court procedures including due process of law and rules of evidence; the principles of family and marital counseling; and child placement techniques. They should also be able to communicate with and understand the problems of culturally and economically deprived families; utilize appropriate community resources and services; and develop and maintain effective working relationships with clients, relatives, the courts, local law enforcement agencies, and the public.

Once hired, protective service workers have to be trained to deal with clients from a new perspective. Whereas they previously worked with people who voluntarily sought their services, they must now learn how to persuade clients to accept help. Workers have to learn how to approach parents in a nonjudgmental way—without fear and without disdain for the situations they have to face. They must also learn all the state and federal regulations relating to child abuse and neglect.

The Hennepin County CPS Unit has a minimum six-month probationary period for new staff members. During this period, workers are evaluated not only on their acquisition of required skills but on their adjustment to the protective service field. Even highly motivated workers can become depressed by daily encounters with people in acute distress and by the brutality, pain, and emotional crises of their clients. A current CPS supervisor offers his own experience as an example: "When I started as a caseworker, I was physically sick every morning for the first two months. I had to force myself to go to work. Finally, I got my perspective and was able to leave my clients at the office. Some workers are unable to master this, and we understand. To be a really good practitioner, you have to gain a certain detachment,

yet retain your compassion and enthusiasm for helping people. You also have to guard against becoming cynical and callous."

The supervisor of each CPS subunit grades new workers at the end of the probationary period, and recommends whether they be elevated to permanent status and the rank of principal social worker. New practitioners work very closely with their supervisor until they are trained and experienced. They are then given wide latitude in the handling of cases, although supervisors participate in and are responsible for all major decisions in a case—when to take action to remove a child from the home, when the child should be returned, when to seek court action to terminate parental rights.

To strengthen caseworkers' skills, CPS conducts a number of in-service training workshops and seminars, covering such subjects as goal development, treatment for drug and alcohol problems, psychological services, interview techniques, family therapy, child placement and foster care practices, and casework skills. In cooperation with the department's legal services unit, caseworkers are also being trained in court procedures and the preparation of court actions.

CPS caseworkers average approximately five years with the Unit. Only about six staff members leave each year—usually for such reasons as pregnancy, retirement, returning to school, or moving out of town. According to CPS officials, the low turnover is the product of both the challenging nature of the work and the high pay. In 1974, the salaries of principal social workers ranged between $1,064 and $1,426 per month; the pay scale for supervisors, between $1,208 and $1,618 per month. Protective service workers in Hennepin County are among the highest paid in the nation.

Dr. Vincent De Francis of The American Humane Association lists several additional reasons for the low staff turnover in the Hennepin County Unit: the specialization of the program, support in funding for expansion of the staff, training, the special status (rank) within the department given to CPS caseworkers, good supervision, shared decision making between caseworkers and supervisors, and the care given to recruiting new staff members.

Improving the Service

CPS officials have established a section to plan, monitor, and evaluate the Unit's services. Aspects of the service are being studied in an attempt to improve their effectiveness. For example, the Unit is evaluating residential treatment centers to determine whether the centers are providing therapeutic help for children or are simply functioning on a caretaker basis. Some CPS officials believe treatment centers should be required to provide monthly progress reports on each child.

The following are among current activities to improve the Unit's service:

- To strengthen the community's awareness of child welfare services, the Unit is sponsoring a series of public-service television announcements.
- CPS staff members have been campaigning for an expanded state reporting law that would cover neglect as well as abuse and would extend the reporting mandate to school personnel and social workers.*
- Unit supervisors are trying to improve in-service training by bringing caseworkers together with psychiatrists, foster care specialists, and other resource personnel. According to a recent survey, most staff members felt that their formal education did not prepare them for handling cases of child abuse and neglect and that present in-service training also fell short of their needs.
- Caseworkers have been seeking improvements in the Unit's recordkeeping system. They feel the system is focused too sharply on accounting for the number of client contacts each worker makes a day, rather than on keeping track of the location of reported children and the quality of services families are receiving.

From a broader perspective, long-range planners for the welfare department are looking at ways to better integrate all health and social services. Although three or four years may be needed

*Under the provisions of the federal Child Abuse Prevention and Treatment Act of 1974 (PL 93–247), states qualifying for federal assistance must have in effect a reporting law that covers child neglect as well as abuse.

for actual changes to be incorporated, CPS clients would benefit from better coordination of welfare and income-maintenance programs, mental health and retardation services, alcohol and drug rehabilitation services, and in-patient and out-patient health services. According to one department official: "What we are now studying are possible system changes to remove barriers for the client who is negotiating the system, such things as coordinating referrals and smoothing out eligibility requirements. We hope to design the system so that it is treating people rather than categories of problems."

Changes to improve the quality of protective services are nothing new to Hennepin County, Minnesota. For the past 30 years, its welfare department and CPS Unit have continually structured and restructured their programs, philosophy, and policies to meet the needs of children and families in the county.

Reference*

1. Child Welfare League of America, *Standards for Child Protective Service*, pp. 3-4.

*Complete source information can be obtained in the bibliography.

Chapter 3
Doctors and Hospitals*

When a child seen in a physician's office or in a hospital emergency room presents symptoms of cystic fibrosis, diabetes, or leukemia, the attending physician usually orders an immediate diagnostic workup. If the diagnosis is confirmed, treatment then begins. In the same situation, however, the child presenting signs of abuse or neglect—an equally serious, life-threatening problem—may not be accorded similar consideration and care.

Like cystic fibrosis or diabetes, child abuse and neglect is a familial problem. Its diagnosis must be approached with the same logical, step-wise sequence used with all other serious problems that run in families. Yet, for some reason, many physicians find it difficult to approach this problem in the accustomed way. Some fail to consider the possibility of maltreatment, and limit their work to the treatment of children's injuries. Some physicians who do suspect abuse or neglect fail to report these cases. Others seem to assume that their responsibility to the child and family ends once a report is made.

This chapter outlines the role of the physician in diagnosing cases of suspected child maltreatment, and discusses the multidisciplinary diagnostic consultation team as a means to facilitate both medical diagnosis and case management in general. This material is not intended for specialists in the field. Its purpose is

*This chapter has been adapted from two sources: *The Diagnostic Process and Treatment Programs*, written by Dr. Ray E. Helfer for the Office of Child Development in 1974; and material written by Norma Gordon for OCD in 1974.

to inform physicians and other medical professionals of the basic process in developing the diagnosis of child abuse or neglect.

Medical Diagnostic Assessment

The Initial Examination. The identification of child maltreatment begins with the recognition of often subtle signs and indicators in the parents' behavior and the child's condition. Chapter 1, Volume 1 presents various characteristic conditions and behaviors that warrant consideration of the diagnosis of abuse or neglect. A summarized list is presented in Table 1.

Upon initial examination, the physically neglected child may exhibit any of the following conditions: diaper rash, cradle cap, poor skin hygiene, below the expected growth average for age and sex (in the examination of an infant, present weight should be checked against birth weight), signs of malnutrition or dehydration, skin turgor, or irritability. Physical findings associated with abuse may include burns; lacerations; abrasions; bruises; soft tissue tenderness or swelling; ecchymoses; hematomas; hemorrhage of the eyes; deformities of the long bones; irregularities of the cranial contour resulting from skull fracture; injury of the external genitalia; limited motion of an extremity; old healed lesions; evidence of bone dislocation, injury, or fracture; symptoms of drug withdrawal; coma; or convulsions.[1] When severe, either abuse or neglect can result in death.

Table 1

Some Indicators* of Child Maltreatment**

The Parent	The Child
Presents contradictory history.	Has an unexplained injury.
Presents a history that cannot or does not explain the child's injury or condition.	Shows evidence of dehydration and/or malnutrition without obvious cause.
Is reluctant to give information.	Has been given inappropriate food, drink, and/or drugs.
Gives a history of repeated injury.	

Projects cause of injury onto a sibling or third party.

Hospital "shops"—has taken the child to a different doctor or hospital each time medical attention is needed.

Has delayed unduly in bringing the child for care.

Refuses consent for further diagnostic studies.

Shows loss of control, or fear of losing control.

Shows detachment.

Reacts inappropriately to the severity of the child's condition—either overreaction or underreaction.

Complains about irrelevant problems unrelated to the injury or condition.

Has unrealistic expectations of the child.

Cannot be located.

Presents a history of family discord, or of personal problems such as alcoholism, drug addiction, abuse or neglect as a child, or psychosis.

Shows evidence of overall poor care.

Is unusually fearful.

Shows evidence of repeated injury.

Begins to care for the parents' needs.

Is described as "different" or "bad" by the parents.

Is indeed different from other children in physical or emotional makeup.

Is dressed inappropriately for degree or type of injury.

Shares evidence of sexual abuse.

Shows evidence of repeated skin injuries.

Shows evidence of repeated fractures.

Has injuries not mentioned in history.

*The diagnosis of child maltreatment should be considered when *some* of these indicators are present. For a more detailed presentation of characteristics of abused and neglected children and their parents, see Volume 1, Chapters 1 and 2.

**Adapted from Helfer and Kempe, "The Child's Need for Early Recognition, Immediate Care and Protection," in *Helping the Battered Child and His Family*, ed. Kempe and Helfer, p. 73, Table 1.

Due in part to the proliferation of gruesome pictures and descriptions of children battered, burned, and tortured by their parents, the nature of child abuse and neglect is often misunderstood. The maltreated child may present symptoms ranging from mild to serious. Identification of the severely battered or neglected child is not difficult; at this stage, most laymen could make the diagnosis. The challenge is to recognize the problem early, when treatment can be most effective. It has been estimated that in at least 10 percent of all cases of children brought to the emergency room for treatment of an injury, the diagnosis of maltreatment should be considered.

Ideally, the history should be obtained by the attending physician, since he or she is best equipped to ask specific questions related to the examination. The parents' explanation of the child's present condition and medical history should be recorded as completely and accurately as possible.

Rarely does one know the true instrument and timing of the child's injury and the exact identity of the perpetrator. In most cases, the diagnosis of child abuse or neglect must be made without the help of a confession. Neither the physician nor anyone else should confront the parents with the illogic of an explanation, assign guilt, or attempt to determine who abused or neglected the child. Accusations or accusatory questioning may not only be unfounded, but will most likely produce a negative or hostile response from the parents. Efforts to elicit a confession can, in fact, jeopardize the success of subsequent treatment.

Written Procedures. Every hospital should have a written set of procedures for handling cases of suspected child abuse or neglect. The instructions should be simple and specific, perhaps in checklist form, and should be available in the emergency room and other hospital areas where children are seen. In addition to instructions on how to proceed if maltreatment is suspected—such as whom to notify for consultation or reporting purposes, and when to hospitalize a child—the list could include a summary of possible indicators of abuse and neglect.

Hospitalization. There are divergent opinions on the issue of hospitalizing children whose conditions do not medically indicate admission. According to one view, short-term hospitalization is

needed in all cases of suspected abuse and most cases of suspected neglect in order to develop the diagnosis, protect the child, and initiate a treatment program. Accordingly, the decision to hospitalize should be based solely on one's concern about the possibility of abuse or neglect, and on the child's age. If the possibility of maltreatment is seriously considered, the young child (age five or younger) should be admitted for diagnostic evaluation; with children age six and older, hospitalization is often necessary, but can be determined on a more individual basis. Those who advocate such a policy recognize that hospitalization can produce emotional stress in children, but feel that the high rates of mortality and permanent morbidity associated with child maltreatment override this concern.

Quite the opposite opinion is held by others. As the supervisor of a large metropolitan county's child protective service program states: "We rarely find the need to hospitalize a child who has been involved in abuse or neglect in order to develop a diagnosis and initiate a treatment program. The prime purpose of hospitalization is to attend to the medical needs of the child. The psychological ramifications of indiscriminate hospitalization are apparent."

Taking an intermediate position on the question, one hospital advises its staff that admission should be seriously considered if an injured child is less than two years old, or if there is evidence of prior injury, longstanding neglect, or failure to thrive. According to the hospital's written set of procedures for cases of suspected maltreatment, the child's safety should be the primary criterion for deciding admission if hospitalization is not medically indicated. Staff members are advised to explore possible alternatives to admission—such as emergency foster placement with protective services or release to a responsible adult with whom the child can safely stay. If no other place of safety is available while further diagnostic evaluation is conducted, the child is to be hospitalized.

Every hospital should formulate a policy concerning the admission of suspected abused or neglected children. Whatever policy is adopted, it should be coordinated with the local child protective service program; it should contain clear and detailed guidelines for staff members; and it should be included in the written

set of procedures for handling cases of suspected abuse and neglect.

Some states allow physicians or hospital administrators to admit a child to the hospital without the parents' consent. (This action requires a court order the next court day.) If the parents are treated with sympathy and sensitivity, this law should rarely have to be invoked.

By relying on the same technique used with any other serious illness, most physicians should not find it difficult to convince the parents of the need for hospitalizing their child. For example, if an anemic child is found to have multiple bruises, many nodes, and a large spleen, admission is needed for diagnostic workup and the development of a treatment plan. The parents are told that the child has an anemia or low blood, and should be hospitalized for further tests. Obviously, the physician would not say, "I think your child has leukemia and should be in the hospital." If the parents ask whether the child has leukemia, the physician would most likely say, in all honesty: "I'm really not certain, and I know you're concerned. But we'll try to find out as quickly as possible."

Similarly, if child abuse or neglect is suspected, the parents should be told that it is necessary to do some studies, gather more information, and work out a treatment plan. It is vital to be honest with families about what is being done and why the action is necessary. When informing the parents that the child should be hospitalized, words such as the following are essential: "I know you're upset about this problem. We'll work out a plan that will be helpful to you." If the parents ask whether maltreatment is suspected ("Do you think I'm beating my child?"), the physician's immediate reaction should be one of honesty and concern: "I don't really know how your child was hurt. You must be very upset. Let's bring him in and see what we can do to help." This technique works more than 90 percent of the time. The parents should be encouraged to remain in the hospital with the child, 24 hours a day if possible.

In view of recent trends toward open hospital records, information about a child or parent should be recorded in such a way that it will not be harmful if seen. The admissions diagnosis,

for example, should objectively describe the physical findings—such as fractured arm, multiple bruises, severe diaper rash, extreme irritability—rather than noting "child abuse" or "battered child syndrome."

The Diagnostic Workup. Many of the procedures and tests included in the diagnostic workup will vary with the child's condition. For example, if physical signs of maltreatment are visible, photographs should be taken. These are a necessary part of the child's record, and are important in documenting findings should the case later be taken to court. (Some states allow photographs to be taken without the parents' permission; in other states, a consent form must be signed.)

If there are indications that trauma has been sufficient to cause bone injury, the diagnostic assessment must include X-ray surveys. The X-ray is the single most valuable tool in detecting a history of battering. X-rays may reveal subperiosteal hemorrhages, epiphyseal separations, periosteal shearing, metaphyseal fragmentation, "squaring" of the metaphysis, previous fractures in various stages of healing, or foreign objects in the body.[2]

If there is multiple bruising or if the parents state that the child bruises easily, a coagulation survey—including prothrombin time, thrombin time, partial thromboplastin time, bleeding time, platelet count, and tourniquet test—should be ordered to determine whether the child has a bleeding disorder. Other specific laboratory tests may include a hemotologic screen and a urinalysis, if internal bleeding is suspected; and examination of the protein and fat content of the stool, if there is a possibility of malnutrition.

The diagnostic workup should also include nursing notes on both the number of parental visits, and characteristics of the interaction between the child and parents. All professional staff members should record any pertinent observations on the parent-child interaction.

The Special Problem of Failure to Thrive. For the purpose of this chapter, "failure to thrive" is defined as the condition of an infant (generally less than one year of age) who fails to grow in height and weight and to develop in personal-social, adaptive, language, or fine and gross motor areas, as compared to pre-

established standards over a period of time (generally several weeks). The comparative standards are the usual growth grids and developmental criteria, such as the Denver Developmental Screening Test.

In more than 80 percent of all cases, the cause of failure to thrive lies in one of four areas: problems associated with the central nervous system, the renal system, the cardiac system, or mothering.* All failure-to-thrive babies should be hospitalized, and no more than two days should be needed to evaluate the three major organic causes. As with all other medical problems, the diagnostic assessment should be orderly and well planned. Most of the problems with the heart, the kidneys, or the central nervous system that produce failure to thrive can be diagnosed with the help of a complete history, a physical, and a few well-planned laboratory studies—done either in the physician's office or within the first 48 hours in the hospital.

If the cause does not appear to be organic, seven to ten days must be allocated to the problem of minimal mothering, accomplished through intense nurturing of the baby by people specifically assigned to this task. During this period, careful observation and measurements of growth and development should be made. A large portion of these failure-to-thrive babies—possibly as many as two-thirds—will thrive with this plan. If the baby grows and develops with nurturing, the case must be handled as any other case of suspected abuse or neglect. If the baby does not thrive with nurturing, the diagnostic assessment should explore the more uncommon causes for the problem.

Reporting. In all 50 states, the District of Columbia, the Virgin Islands, and Guam, physicians are legally required to report cases of suspected child maltreatment. Physicians are specifically designated as mandated reporters in most states; in the others, their inclusion in this category is implied. In Indiana and Texas, "any person" is a mandated reporter; and in New Hampshire, Tennessee, and Utah, reporting is required of "any person," although administrators of hospitals or similar institutions "shall report" (in

*The term "mothering" means caring for and nurturing a child—including picking up, talking to, feeding, smiling at, cuddling, and rocking the child. Mothering can be done by various people, the natural mother being one. The term "parenting" is proposed by some.[3]

Tennessee, they "may report") in lieu of staff. In addition, various states' reporting laws specifically require surgeons, osteopaths, dentists, residents, interns, hospital administrators, practitioners of the healing arts, chiropractors, pharmacists, nurses, podiatrists, and religious healers to report. (See Volume 1, Chapter 3, Table 2 for a listing of mandated reporters by state.) All reporting laws provide immunity for mandated reporters.

Despite their legal responsibility, physicians have traditionally been reluctant to report. The consequences of not reporting a case of suspected abuse or neglect can be damaging to the physician, as well as to the child and family in question. In one case, reported by *Time* magazine (November 20, 1972, page 74), a man whose child had suffered severe mental retardation as a result of physical abuse brought a $5,000,000 suit against four doctors for failure to report the child's injuries, and against the city and the chief of police for inadequate investigation once a report was made. The physicians and the police agreed to a $600,000 settlement.

Reporting procedures vary from state to state. If the child is hospitalized, the policy of some hospitals is to delay the report briefly until a more thorough diagnostic assessment can be performed. (It should be noted that delays in reporting can be dangerous, particularly if there are other children in the home.) Some hospitals immediately report by phone, and follow up with a written report a day or two later, when tests and evaluations are complete. All hospitals should have a definite procedure for reporting, developed in conjunction with the local child protective service agency (or whichever local agency receives and investigates reports). All medical personnel should know what to report, when, and to whom.

The parents must always be informed that a report is to be made. One doctor uses the following procedure: he tells the parents that, as a practicing physician, he must report all children's injuries when their cause is not clear; he then explains the contents of the report, to whom it is sent, and what will happen once the report is received. If the attending physician does not know what happens after the report is made, a hospital social worker or some other designated staff member should discuss this with the parents.

The Initiation of Treatment. Treatment should begin as soon as the diagnosis of abuse or neglect is suspected. This is done by placing emphasis on the parents rather than on the child alone. Parents who have the problem of child abuse or neglect tend to be very frightened, angry, and distrustful people. Their ambivalence is often great: they typically do not want to hurt their children and are anxious for someone to help them, but they trust few people if anyone. Those who move from hospital to hospital are not so much afraid that someone will discover the abusive or neglectful behavior—most are shopping for someone who will perceive their problem and help them. Many parents become angry if they are offered help, but even more angry if no help is offered.

Treatment is beginning throughout the diagnostic process. The parents must be kept informed, in a painstaking manner, and must be dealt with honestly, but with reasonable judgment that they are not being told more than they can accept at any time. Expressions of concern and understanding are helpful: for example, "You must be upset"; "It's all right to get angry"; or "Let's see what we can do to help you."

Physicians often circumvent their own feelings in abuse and neglect cases by talking to the parents only about the child. They seldom ask the parents how they are feeling and getting along. The pediatrician should make appointments to see the parents alone, without their child. The parents should be given the clear impression that their child does not have to be injured or sick in order for them to see the doctor—that they can and should call or come in whenever they are troubled or upset.

The Multidisciplinary Diagnostic Consultation Team

With most difficult problems that physicians and nurses face, a wide range of people is needed to provide emergency care, to clarify patients' problems, and to implement a meaningful treatment program. For example, in the case of a 45-year-old man who has a sudden, near-fatal coronary, a number of people are suddenly important in this man's life: the personnel of the rescue squad, the emergency room staff, nurses and others in the cardiac intensive care unit, hospital technical staff, ward nurses, home care and vocational rehabilitation planners, visiting nurses, and

of course, his physician. Each of these professionals is dependent on the others; and unless each is readily available, the work of all will suffer.

The assessment and treatment of a difficult case of child abuse or neglect requires a similarly interdependent multidisciplinary group. Specific bits of information must be collected to determine if the criteria for diagnosis are present in a given family. The gathering of these data may require the skills of many disciplines, such as social work, nursing, psychiatry, psychology, pediatrics, and others. As in the case of the coronary, none of these disciplines can adequately manage a difficult case alone.

The purpose of a diagnostic consultation team is threefold: to consult with physicians and other professionals who are not specialized in the handling of suspected abuse or neglect cases; to support child protective service caseworkers who are responsible for assessing reported families and developing plans for their treatment; and, most important, to facilitate the provision of appropriate help to children and families. Diagnostic consultation teams for cases of suspected child abuse and neglect function similarly to cardiac diagnostic teams: the role of each is to assess difficult cases and to recommend a treatment plan.

Consultation teams are known by various names—the SCAN (Suspected Child Abuse and Neglect) Team, the DART (Detection, Admission, Reporting, and Treatment) Team, the Trauma X Group, the Child Protection Team, the Child Abuse Consultation Team—and range in size from three members (a physician, a social worker, and a coordinator) to large multidisciplinary groups (including, for instance, the CPS worker in charge of the particular case, a hospital social worker, a pediatrician, a public health nurse, a psychologist or psychiatrist, a lawyer, a police officer, and a salaried coordinator).[4] Regardless of their size and location (whether based within or outside the hospital), teams generally have a number of basic functions. They gather the data needed to make a diagnosis; serve as consultants to physicians and other professionals; meet regularly to discuss case referrals; help support the family throughout the diagnostic process; collate data at case conferences; and recommend a plan for family treatment to the protective service worker in charge of the case. Many teams also assume the responsibility for reporting cases identified within the

hospital, and prepare physicians for testifying in court. A member of the consultation team may even accompany the attending physician to a court hearing.

Table 2

A Diagnostic Approach: Comparison Between Suspected Abuse or Neglect and Suspected Lead Encephalopathy

Diagnosis of Child Abuse or Neglect	Diagnosis of Lead Encephalopathy
1. Physical findings* not explained by history	1. Convulsion without head injury, history of seizures, etc.
±	+
2. Laboratory data:* specific for child's condition	2. Red cell stippling and fragility changes, high blood lead level, etc.
±	±
3. X-ray changes*	3. Lead lines, plaster in abdomen
+	±
4. Child lives in family with the potential for child maltreatment**	4. Child lives in lead environment
+	±
5. Child is or is seen by parents as different from other children**	5. Child has personality trait leading to pica
+	±
6. Presence of family crisis(es)**	6. Child develops colds, diarrhea, fever, etc.

Note: Pluses and minuses for the two problems vary.

*See previous section, "Medical Diagnostic Assessment."

**These factors would be explored in the social worker's and, in some cases, the psychiatrist's or psychologist's assessment of the family. For a discussion of these factors, see Volume 1, Chapter 2.

To illustrate the importance of multidisciplinary diagnostic consultation in a difficult case of suspected abuse or neglect, Table 2 compares—in simplified form—the approach to a case of suspected child maltreatment to that of suspected lead poisoning. When a child shows symptoms of possible lead poisoning, some basic information is needed. For example: Does the child's home meet the criteria for lead poisoning? Is there lead paint around? Is plaster chipped off the walls? Does the child eat this material? Is the family such that they cannot or will not do anything to protect the child in the lead environment? In brief, is the home safe for the child? If not, what can be done to make it safe?

When a child presents signs of possible maltreatment, similar basic questions must be explored. The data needed to diagnose child abuse or neglect come from many different sources, including the physician's and nurses' observations, sometimes the child's teacher's observations, laboratory and X-ray findings, and social work and psychiatric assessments. As with other serious and complex diagnostic problems, a case conference is necessary for the review of all data and the formulation of a treatment plan. The participants are those who have bits and pieces of information that will contribute to a more complete picture of the family's problems and needs. At the case conference, the problems of the family are listed; a decision is made on whether the home is safe for the child (see Table 3); if it is, appropriate follow-up is arranged; if it is not, a treatment plan is formulated and recommended to the CPS caseworker; responsibilities for further involvement with the family are delegated within the group; and a long-term coordinator is designated to follow up on the family's progress. (Treatment may last many months or even years.)

Diagnostic consultation teams are generally staffed by professionals who volunteer their time to the group in order to make their own involvement in cases more effective. For example, one team has held regular weekly meetings during the lunch hour for the past several years.

When a hospital is unable to staff a diagnostic consultation team or has too few cases to warrant a specialized team, the establishment of a joint consultation team—staffed by and available to professionals from several local hospitals—should be considered.[5] One local physician could be trained as a consultant for area

Table 3

How-Safe-Is-The-Home Checklist

A. Physical findings
   1. Are they explained by history?
   2. Do they represent nonaccidental injury or neglect?
   3. Did child thrive in the hospital?

B. How does each parent perceive
   1. His/her rearing?
   2. His/her parents now?
   3. Others?
   4. Him-/herself?
   5. His/her spouse?
   6. Children in general?
   7. The child in question?
   8. The child's siblings?

C. How are crises handled by the parents?
   1. Emotional crises (personal problems)?
   2. Logistical crisis (problems with transportation, finances, food, etc.)?

D. Do the parents
   1. Know much about child-rearing?
   2. Know the skills of caring for a baby?
   3. Know anything about child development?

doctors and hospitals. He or she could perhaps be paid for consultation services by the hospitals involved in the joint program or by the local child protective agency. A social worker from one of the local hospitals or from the child protective agency could similarly be designated to the joint consultation team.

Obviously, not all physicians are expected to become specialists in the area of child abuse and neglect. But if physicians and other medical professionals are to provide maltreated children with the same care and consideration given to other suffering people, they should recognize that they have certain basic responsibilities and limitations. Physicians should be just as familiar

with the signs and symptoms of maltreatment as with the symptoms of any other life-threatening disease. In addition, every medical professional should know how to recognize and approach suspected cases, and when to call in specialized help.

The medical profession—like each of the many disciplines involved in cases of abuse and neglect—must consider itself an integral part of a chain of action needed to protect the well-being of children and families. Helping the abused or neglected child and his or her family requires the concentrated efforts of many people and professions working together toward one common goal—a physically and emotionally healthier family.

References

1. For a review of physical findings in cases of abuse and neglect, see Weston, "The Pathology of Child Abuse," in *The Battered Child*, ed. Helfer and Kempe, 1974, pp. 61-86; and self-instructional material by Barton Schmidt, available from the National Center for the Prevention and Treatment of Child Abuse and Neglect, 1001 Jasmine, Denver, Colorado, 80220.

2. For a review of radiological findings, see Silverman, "Radiological Aspects of the Battered Child Syndrome," in *The Battered Child*, ed. Helfer and Kempe, 1974, pp. 41-60.

3. For discussion of early mother-child attachment or "binding," see Klaus and Kennell, "Mothers Separated from Their Newborn infants"; and Fanaroff, Kennell, and Klaus, "Follow-Up of Low Birth Weight Infants—The Predictive Value of Maternal Visiting Patterns." See also Volume 3, Chapter 6.

4. For descriptions of specific multidisciplinary diagnostic consultation teams, see Newberger et al., "Reducing the Literal and Human Cost of Child Abuse: Impact of a New Hospital Management System"; and Bowden and Hildebrandt, "The SCAN Team in a University Hospital." In addition, see the appendix of Volume 3, particularly the description of the Honolulu program.

5. Delmero, Hopkins, and Drews, "The Medical Center Child Abuse Consultation Team," in *Helping the Battered Child and His Family*, ed. Kempe and Helfer, p. 162.

Chapter 4

A Case Study of the Child Abuse Unit, Los Angeles Police Department*

The role of the police in cases of child abuse and neglect generally involves any of four prime functions: identification, receipt of reports, emergency intervention, and investigation. Police response to this role varies with the community and is determined by such factors as the nature of state laws, including the state's reporting law; the sophistication of the local policy agency; the capability and resources of the local child protective service agency; and the degree of cooperation among local professionals and agencies.

In recent years, law enforcement agencies around the country have been re-examining their responsibilities in the area of child protection. As one expression of law enforcement's growing concern for the problem of child abuse, the National Association of Chiefs of Police has developed a training guide to help sensitize police recruits to the problem. Another such example is the creation of the nation's first specialized child abuse unit in a police agency—the Abused and Battered Child Unit of the Los Angeles Police Department (LAPD).

As the following pages illustrate, the LAPD provides a valuable example of the perspective of a metropolitan police department in a state where law enforcement is actively involved in the management of child abuse. But it should be noted that in many ways Los Angeles provides an insular example of the police role in case management. Due to several factors, the situation in California is unique.

*Much of this chapter has been adapted from material written for the Office of Child Development in 1974 by Kathleen Lyons.

Although the state's reporting law is only one of 31 nationwide providing for receipt of reports and investigation by the police, the police in California have a far more active role in case management than is typical in other states. Even California's central register of reports is maintained by the Department of Justice, Bureau of Criminal Identification and Investigation; it is the only statewide register in the country maintained by a police authority. In addition, California as a whole lacks a strong child protective service program. In the early 1970s, the Department of Public Social Services (DPSS) made an intensive effort to develop a good statewide CPS network; but because of inadequate funding, most of their gains have been dissipated.

Like 13 other states and Guam, California includes its reporting statute under the state penal code. The legislative definition of and proscribed punishment for specific forms of child maltreatment are found in the following sections of California law:

- Section 273a of Deering's Penal Code (P.C.) (Willful Cruelty Toward Children: Endangering Life, Limb, or Health: Punishment): "Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of such child to be injured or willfully causes or permits such child to be placed in such situation that its person or health is endangered, is punishable by imprisonment in the county jail not exceeding 1 year, or in the state prison for not less than 1 year nor more than 10 years.

  "Any person who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of such child to be injured, or willfully causes or permits such child to be placed in such situation that its person or health may be endangered, is guilty of a misdemeanor."

- Section 273d P.C. (Infliction of Traumatic Injury Upon

Wife or Child): "Any . . . person who willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition, is guilty of a felony, and upon conviction thereof shall be punished by imprisonment in the state prison for not more than 10 years or in the county jail for not more than one year."

- Section 288 P.C. (Crimes Against Children: Lewd or Lascivious Acts: Punishment): "Any person who shall willfully and lewdly commit any lewd or lascivious act . . . upon or with . . . a child under the age of fourteen years, with the intent of arousing, appealing to, or gratifying the lust or passions or sexual desires of such person or of such child, shall be guilty of a felony and shall be imprisoned in the state prison for a term of from one year to life."

This chapter neither promotes nor discourages the role that the LAPD has assumed. Its purpose is simply to describe how one police department approaches the problem of child maltreatment in its community.

Background

The 7000-member Los Angeles Police Department comprises 17 decentralized geographic divisions within a city that covers almost 500 square miles and has a population of more than 2,800,000.

The LAPD began specialization in juvenile affairs almost three-quarters of a century ago. In 1909, the first juvenile officer was designated, and a separate juvenile bureau was created the following year. Through most of its history, the juvenile division has existed as a separate entity within the LAPD—permitting a degree of specialization among its officers—and has traditionally used referrals to social service agencies whenever possible. Because of the special expertise required of investigators in cases of suspected child abuse, an "abused and battered children" desk was set up in the juvenile division in 1970. Sergeant Jackie Howell was designated to research the problem of abuse, survey the department's policies and procedures, and make recommendations regarding further departmental needs in the area of child abuse.

In January 1974, the Abused and Battered Child (ABC) Unit was established, primarily in response to three findings from Howell's study of the department's past handling of cases: the lack of reliable statistics on cases involving child maltreatment; lack of expertise in the investigation of cases; and officers' dissatisfaction with their training for handling abuse cases.

Unreliable Statistics. Because reliable statistics were not available and because the department had previously lacked concentrated attention to the problem of abuse, Sergeant Howell had trouble obtaining needed information on child abuse cases. Abuse cases were included in the general category of "crimes against the family" and were difficult to separate out. Although California has a central crime registry accessible to all law enforcement agencies in the state, it was unable to produce adequate statistical data.

However, the available data did indicate an increasing number of reported cases of abuse. There were also indications of inadequate reporting, incomplete investigations, and unsatisfactory dispositions in some cases that had come to the attention of the police.

Between 1962 and 1970, reports of suspected child beating in Los Angeles increased 38 percent, while the number of related arrests declined six percent. Homicides resulting from child abuse or neglect have more than doubled since 1965. That year, there were seven proven homicides involving children under 11 years of age*; in 1971, there were 16. Since 1971, when the department began more specialized handling of abuse cases, the number of reported incidents has increased further, as illustrated in Table 4. In its first year of operation, the ABC Unit handled 837 abuse and neglect cases in which children were placed in custody, plus 13 homicide cases. In total, 269 adults were taken into custody.

It is hard to tell whether the increase in reports reflects an actual increase in maltreatment, or improved reporting procedures and greater public awareness. Police investigators in Los Angeles believe that both factors are involved.

*California's child abuse law formerly specified age 12 as the upper limit for coverage. In January 1974, amendments of the reporting law and penal code statutes extended coverage to age 18.

Table 4

Number of Children in Custody and Homicide Cases, LAPD, Juvenile Division

	1971	1972	1973	1974*	Change from '71-'74 (percent)
Physical Abuse	228	299	319	524 (364)	+ 129
Endangering and Neglect	831	1197	1488	1550 (404)	+ 85
Sexual Abuse	22	81	90	109 (69)	+ 395
Homicide (Victim Younger than Age 11)	16	26	20	24 (13)	+ 50

*The ABC Unit was created in 1974. Figures in parentheses reflect cases handled by the Unit and are included in the 1974 totals for each category.

Since the creation of the ABC Unit, police and social service officials have begun plans to establish a central register of reports for the county. In the meantime, the Unit is accumulating a data base for use by specialists both within and outside the department in devising programs to deal with the problem of child maltreatment.

Lack of Investigative Expertise. In addition to problems in the statistical recording of cases of child abuse, Sergeant Howell found indications of incomplete or inadequate case investigations, and a need for specialized abuse investigators. One example is the investigation of coroner's cases—cases in which no doctor has signed the death certificate. In 1971, there were 215 such cases involving children aged 10 and younger, including 153 cases involving infants under one year of age. Table 5, a sampling of police records from 1971, illustrates the need for specialized investigation.

Officer Dissatisfaction. To further clarify departmental needs, LAPD officers were surveyed in 1971 and asked to rate their own effectiveness in cases of child abuse. The surveys involved a

random sampling, and the results are believed to have reflected the predominant attitudes in the department. Among the detective division, juvenile coordinators, and juvenile special services personnel, the following results were obtained:

- 67 percent believed that the procedures, criteria, and advice for child abuse cases were either inconsistent or inadequate.

Table 5

Samples of Police Reports of Coroner's Cases, 1971

Child's Age	Official Cause of Death	Comments
5 Weeks	Undetermined	Around his throat, victim had a four-inch-long ring which parent stated had been present since birth. Bassinet pillow stained with substance resembling blood.
16½ Months	Natural	Treated at age four months for burns on both legs from which scars resulted. Treated one month prior to death for anemia. Extremely undernourished at time of death.
12 Months	Accidental Drowning	Babysitter states that the baby, who was three-feet tall, fell head-first into a scrub bucket two-thirds full of water; that the water reached the baby's waist; and that his feet were sticking up in the air. The plastic bucket did not tip over.
2 Months	Natural	No crib for child. Not treated by physician since birth. Six-year-old dropped victim to floor.

- 77 percent agreed that their heavy caseloads delayed response time to informal reports of abuse or neglect. (The average delay between complaint and investigation was about two days.)
- 80 percent indicated that patrol officers lacked the expertise to handle cases properly.

A survey of patrol officers yielded the following data:

- 70 percent admitted that they did not check for child abuse when investigating such calls as family disputes and "drunk and disorderly" complaints.
- 50 percent found the procedures and criteria for abuse cases inconsistent or inadequate.
- 71 percent claimed the tendency to lose their objectivity when involved in cases of crimes against children.

There was a general feeling in the department that child abuse involves a set of dynamics different from other police work, and that cases should be handled by specially trained officers.

A final consideration leading to the establishment of the ABC Unit was that many agencies and community groups were expressing concern over the problem of child abuse, but this concern was not being translated into effective programs of action. Administrators of the police department were convinced that the police had to assume a position of leadership in dealing with this problem that showed no signs of dissipating on its own.

The ABC Unit

One of five subsections of the LAPD's juvenile division, the ABC Unit is staffed by five man/woman investigative teams, a desk officer, plus several civilians to help with clerical work. Sergeant Jackie Howell is the officer in charge. Officers with the Unit are chosen on the basis of previous experience, ability, and interest in the assignment. Most are young and have families of their own.

The Unit's first-year budget—$240,000—came entirely from city funds and materialized, at least in part, because of active com-

munity support for the creation of the specialized Unit. At present, the Unit handles only cases of physical and sexual abuse; cases of child neglect and endangering are handled by area division juvenile officers. Eventually, the ABC Unit hopes to assume responsibility for all cases of suspected maltreatment.

The Unit receives an average of 700 calls a week, the majority seeking information or advice regarding the problem and management of child abuse. Approximately 100 calls each month are reports of suspected abuse requiring investigator response.

The work of the Unit falls into three main categories: investigation, training, and public relations.

Investigation

According to the prospectus drawn up by Sergeant Howell, the Unit's investigative responsibilities are:

- to receive, verify, evaluate, properly investigate, and complete all complaints involving children suspected of being physically or sexually abused by their parents or guardians
- to investigate all coroner's cases involving children under 11 years of age, where parents or guardians are suspected perpetrators, except for deaths resulting from traffic or aircraft accidents
- to prepare the necessary reports and evidence for case presentation to social service agencies, prosecuting officials, and the juvenile and criminal courts.

While the state's mandate to report covers members of the medical profession, school personnel, social workers, and other professionals who work with children, the predominant sources of reports to the Unit are intradepartmental referrals and calls from DPSS and from private citizens. Each report is followed up within 24 hours by a team of ABC investigators. Officers with the Unit work in plain clothes, rather than uniforms, and drive unmarked cars. The use of man/woman teams is credited with adding greater sensitivity and responsiveness to the Unit's work.

The investigative teams are assigned during normal day-watch hours; an on-call system provides advice and assistance outside

of office hours. Each team is responsible for one of four geographic areas, each of which includes three or more divisions. To reduce driving time, each team usually works out of a division headquarters in its geographic area, and returns to the central ABC office to write reports. Under this arrangement, the teams can become acquainted with the juvenile investigators and desk officers in the various divisions. More important, the rest of the department can become familiar with the work of the Unit. Most of the agencies with which the investigators work—including the DPSS, the city and district attorney's offices, and the courts—operate under a similar decentralized system.

Although the department provides guidelines on how particular cases should be handled, the individual officers must determine such questions as whether to place a child in protective custody and what charges, if any, to file against the adult involved. In their decision making, investigators rely on the physical evidence, the testimony of witnesses, and information from police records and the DPSS.

When a child has been injured, the investigators' first responsibility is to take the child for medical attention. A child may be placed in protective custody if his home "is an unfit place for him by reason of neglect, cruelty, depravity, physical abuse of either or both of his parents, or of his guardian or other person in whose custody or care he is." When possible, injuries are photographed and the attending physician is asked for professional advice on the nature of the injuries and the need for placing the child in protective custody.

After ensuring proper medical treatment and transporting the child to the city's central receiving facility for abused and neglected children, officers continue with their investigation. Members of the family and potential witnesses are interviewed; items of possible evidential value such as belts, cords, and other instruments of abuse are collected; and, when relevant, photographs are taken of the method or site of the abuse.

An in-custody report must be completed whenever a child is placed in protective custody, and a crime report filed for all abuse and serious neglect cases. If the investigators believe that the child has suffered "great bodily harm," a felony charge is filed with

the district attorney's office. When the child's injury is less serious or when the officers feel there are mitigating circumstances, the case is referred to the city attorney's office where a misdemeanor charge may be filed. In addition to the seriousness of the child's injury, investigators take into account the quality of the evidence, past family history, the attitude of the suspected abuser, and any other circumstances felt to have a possible bearing on the disposition of the case. A felony or a misdemeanor offense, if committed in the officer's presence, may subject the suspect to immediate arrest. In most cases, reports and evidence are submitted to the district or the city attorney for consideration and possible issuance of a criminal complaint.

ABC officers recognize as their primary concern the continued safety of children. This perception of their role has led the Unit's personnel to actively seek alternatives to prosecution. As Sergeant Howell explains: "Even though, on the one hand, we say to the parents that their behavior toward their children constitutes a crime in California, we believe that they need help, and encourage them to accept treatment services now rather than waiting to go through the court system."

Through consultation with representatives of the DPSS and the city attorney's office, a growing number of less serious abuse cases are being resolved on an informal basis. The city attorney's office has begun to hire retired juvenile officers to assist in the disposition of such cases. For example, an informal hearing with the parents and representatives of the police and social services may be held in the city attorney's office to discuss alternatives to criminal prosecution and permanent removal of the child from the home. Faced with the legal consequences of their behavior, parents who may have previously resisted treatment often agree to accept professional help.

There are situations, however, which in the judgment of the police and the prosecutor, require formal adjudication in the courts. Two separate proceedings are involved: a juvenile court hearing to ascertain the future of the child, and a criminal court hearing to determine the guilt or innocence of the suspected abuser. Although the police are sympathetic with the juvenile court's desire to keep families intact, many officers feel that some judges are overly reluctant to separate children from their natural

parents. (At least in part, the juvenile court's cautiousness in removing children from their homes may stem from the lack of adequate foster care or other programs in the area.) Recently, specific judges in one of the juvenile court branches have been designated to hear only dependency cases; members of the Unit hope that this will foster the judicial specialization these cases require.

Successful criminal prosecution of child abuse cases is difficult. Typically, the child is too young or too frightened to testify, and witnesses are reluctant to become involved in a potentially drawn-out and unpleasant legal proceeding. Sergeant Howell notes: "In California, very few people go to jail for child abuse; very few are given more than a probationary sentence. For the most part, the only people receiving jail sentences are those who have killed their children and been convicted of murder or manslaughter."

The Unit's approach to cases involving prosecution is often to recommend that the court impose a probationary sentence, with stipulations for treatment—such as involvement in group therapy or Parents Anonymous. According to Howell: "If a parent is found guilty of child abuse and given nothing more than a $100 fine or a six-month probationary sentence, we feel we have accomplished nothing. We haven't accomplished all our goals, but we are very enthusiastic about how well this approach—probation on the condition of treatment—has worked to date."

Training

According to members of the ABC Unit, the recognition, evaluation, and investigation of child abuse cases require a knowledge of the symptoms of abuse; up-to-date information on case law and statutes; and a familiarity with the roles and responsibilities of social service agencies, the medical profession, and the civil and criminal court systems. To meet these specialized demands, the Unit is responsible for preparing all training programs related to child abuse used in the LAPD's recruit, in-service, and investigation schools, and has developed a specialized program for juvenile division personnel.

As part of their general training, recruits receive 10 hours of

instruction in juvenile procedure, including material on the handling of abuse and neglect cases. Using multimedia instructional packages that allow recruits to proceed at their own pace, the curriculum includes a series of filmed lectures on child abuse, discussions of the department's responsibilities and the philosophy and functions of the ABC Unit, and an outline of the procedures involved in placing a child in protective custody. An expanded curriculum, currently being planned, will include interview techniques and methods of diagnosing abuse. A representative of the ABC Unit tries to meet with each graduating class to answer questions and to urge the new officers to cooperate with the Unit.

Approximately every two years, LAPD officers return to the police academy for a week-long refresher course which includes updated information on case law and evidentiary requirements related to abuse and neglect cases. Officer awareness of the problem of abuse is important, as the following case illustrates.

> *Two patrolmen, driving through an alley, spotted two children playing ball. There was nothing unusual in the scene, except that one officer noticed that the younger boy had a black eye. The patrolmen probably would have driven on, but having just come from an ABC-Unit lecture on child abuse, they stopped and talked to the boys. The elder told the officers that his four-year-old brother had been beaten by their mother the night before and that the beatings were common. The case was referred to the Unit for investigation. As a result of meetings between the mother and representatives of the DPSS and the city attorney's office, the case did not go to court. The woman was advised that a criminal complaint would not be filed on the condition that she seek treatment. Follow-up of the case was assumed by DPSS personnel.*

Patrol officers attending sergeants school are acquainted with supervisory responsibilities in child abuse cases. As supervisors of patrolmen, sergeants are often consulted by beat officers on how abuse cases should be handled and whether a particular case should be referred to the ABC Unit.

To further encourage patrol officers to report suspected child abuse, ABC investigators provide feedback on referred cases and

commend reporting patrol officers to their supervisors. Like other citizens, police officers are more apt to report when they know that immediate and appropriate action will be taken. Members of the Unit visit each LAPD division every few months to alert officers to changes in regulations and to particular cases being investigated in their area. These visits also serve as reminders of the new Unit's existence.

Members of the ABC Unit take part in an eight-day training program, set up by Sergeant Howell after consultation with professionals both within and outside the law enforcement field. The program includes lecturers from U.C.L.A., Childrens Hospital, and the DPSS, and a field trip to the Los Angeles Coroner's Department for study of the Sudden Infant Death Syndrome and routine coroners' procedures. Totaling 66 hours of study, the course comprises the following areas:

- Introduction to the juvenile division: policies and procedures (4 hours)
- Goals and objectives of the ABC Unit (2 hours)
- Public information and community relations (1 hour)
- Recognition and evaluation of child abuse (7 hours)
- Field-investigation techniques involving abuse and deaths of children (21 hours)
- Laws and procedures (5 hours)
- Related agencies and their functions (7 hours)
- Behavioral science aspects of child abuse (16 hours)
- Examination (2 hours)
- Review and evaluation (1 hour).

Public Relations

Community Relations. Over the years, the LAPD has developed a sophisticated community-relations program. Each of the force's 17 geographic divisions has a designated community-relations officer. In addition, the department has adopted what it calls the "basic-car plan." Each of the three or more geographic areas

within each division is assigned a "basic car"—a group of nine officers responsible for getting to know the people who live and work in the area. Sergeant Howell notes that the basic-car plan is an update on the "old beat-cop" concept: "The basic-car team and local residents hold regular monthly meetings and decide what they can do in their own little community concerning crime prevention." Once or twice a year, members of the ABC Unit appear at these meetings—generally attended by 75 to 200 people —to speak and show films about child abuse.

Several years ago, the LAPD, in conjunction with the board of education, initiated a "Police Role in Government" course in the city's junior and senior high schools. The course is required at the junior-high level, and 30 police officers are assigned as full-time instructors in the schools. The syllabus includes such subjects as the administration of justice, criminal and juvenile law, the California court system, and laws pertaining to self-incrimination and search and seizure. Under the direction of the ABC Unit, the problem of child abuse is being added and, whenever possible, a member of the Unit leads the discussion.

ABC personnel regularly participate in panel discussions and seminars on child abuse, and are often interviewed for radio and television. Material including slides, lecture notes, and information on legal and therapeutic considerations is also available to other police officers for use in public presentations. In addition, through the LAPD's public affairs division, the Unit sponsors public-service announcements on radio at least twice a year. Sergeant Howell has found the public generally sympathetic to the ABC Unit, once its goals are clearly understood and the scope of the problem recognized.

Members of the Unit also review and suggest changes to the laws pertaining to abuse cases, and are available to testify before hearings of state senate committees. Recently, the testimony of an ABC officer was instrumental in amending the state's reporting law to require a time limit of 36 hours for the reporting of suspected abuse cases.

Since the Unit's establishment in early 1974, other jurisdictions in the Los Angeles area and from as far as Massachusetts have requested information on its policies and procedures. Requests for

information have also come from students, social workers, psychologists, and interested citizens. From her correspondence with police departments throughout the country, Sergeant Howell is convinced that within the next few years a growing number will be instituting programs to deal with cases of child abuse and neglect.

Interagency Relations. Sergeant Howell notes that the ABC Unit faces more negative stereotyping by the professional community than by the public. "We really don't have problems with our witnesses, with 'the man in the street.' Our biggest problems are with professionals because they have their preconceived ideas, their stereotypes of us and of what we are going to do, without really understanding what our role is. I'm sure, in part, this is based on good reason. Unfortunately, police departments don't always respond as they should. But in defense, I would say this is probably true of all the disciplines involved. When you are dealing with other professionals, everybody wants to be the decision maker."

To counteract interdisciplinary stereotyping and facilitate coordination among agencies involved in abuse cases, some Los Angeles professionals began meeting informally several years ago. Calling themselves the Community Liaison Team, the group has been loosely knit and has included police officers, doctors, social workers, and various other professionals. As Howell explains: "Two or three of us get together on a particular problem; three or four others will get together; and there is a lot of telephone contact. You find that the other fellow is not so bad and actually has a lot to contribute. As this feeling grows, cooperation improves."

For example, as a result of recent informal meetings between medical officials and police officers, one hospital in an investigative team's territory has been designated to handle abuse cases with a commitment to make trauma specialists available for diagnosis, treatment, and court appearances. Other agencies are developing their own programs and assigning specially trained personnel to handle child abuse cases.

Increasingly, members of the ABC Unit and the DPSS work together on cases, encouraging families to seek professional assis-

tance with their problems. ABC investigators refer cases to DPSS if they feel that family problems related to employment, housing, finances, child care, or health have contributed to the incident, or that family members require counseling.

When child neglect or abuse is reported to DPSS, department regulations require investigation within 24 hours. If the DPSS dependency investigator feels that a child is in "clear and present danger," he or she notifies a supervisor who contacts the police. The ability of DPSS to make informed judgments on these cases has been retarded in the past by the lack of complete, up-to-date records. It is hoped that the proposed countywide central register, to which both police and DPSS personnel will have access, will alleviate this problem in the near future. Most criticisms of the Unit by DPSS personnel relate to its current staff limitations: because the ABC staff is small, cases of child neglect and endangering are handled by officers outside the Unit, who are often not able to respond quickly to reports. DPSS investigators seem to agree that the ABC Unit should handle these cases as well as those involving physical and sexual abuse. In fact, several professionals in both agencies have stated that the Unit should serve as a foundation for a family crisis center capable of handling a wide range of family-oriented complaints.

Among DPSS investigators and their supervisors, there are mixed feelings about their lack of authority to remove children from dangerous home situations. However, the majority interviewed were willing to see the police maintain this authority, since its assumption by DPSS personnel could inhibit the growth of trusting relationships with parents.

Cooperative arrangements among the ABC Unit, the courts, the DPSS, and the medical community are producing a growing list of viable alternatives to prosecution. The Unit maintains a list of referral services in the area. Included are such organizations and programs as Parents Anonymous, a self-help group for the problem of child abuse; U.C.L.A.'s Child Trauma Intervention and Research Project, which conducts group therapy for parents; and Friends of the Family, which offers parent education, individual and group counseling, home visiting services, and a crisis-intervention hotline.

Nevertheless, members of the Unit feel that at present the most critical need in Los Angeles is for more referral services. For example, Sergeant Howell notes that currently there are no treatment programs for abused and neglected children, and that treatment programs for parents are limited but increasing.

Proposals have been introduced in the California legislature to create three child abuse centers for the state to provide counseling, medical treatment, and information on referral services. Both police and DPSS personnel hope that funds will also be available for the agencies with traditional line responsibility for cases of abuse and neglect. In addition, members of the DPSS have suggested a pilot program that would use teams representing the social services, the police, and public health to investigate reports.

Also in need of systematization are follow-up procedures for cases referred from one agency to another. Follow-up is currently handled on an informal basis by ABC and DPSS investigators working together in the field.

In general, social workers and their supervisors who have worked with ABC investigators feel there is mutual respect for each other's role in solving family problems. As a letter to the Unit from the Intake and Detention Control personnel in DPSS explains: "The problem of battered, abused and molested children is one which no community likes to recognize. . . . We applaud the LAPD's courage for seeing this problem and effectively dealing with it."

Chapter 5
The Teacher and the School*

Next to the family, the school is generally considered the most important influence on a child's life. The function of the school obviously goes beyond teaching children to read and add and memorize historical facts. In some cases, where the family unit fails to protect or itself threatens the child's welfare, schools can play an invaluable role in saving or salvaging children's lives.

While the most severe cases of physical injury resulting from abuse or neglect tend to involve preschool children, particularly infants, the incidence of maltreatment among children aged 5 to 18 is significant. Dr. C. George Murdock noted in 1970 that, according to some surveys, children of school age are involved in only 20 to 30 percent of abuse cases.[1] Dr. David Gil, on the other hand, estimated in 1969 that this age group accounts for about half of all incidents of physical abuse.[2] Based on estimates by school personnel, one survey concluded that 40 of every 100,000 school-age children are physically abused each year.[3] If this estimate is correct, more than 20,000 children between the ages of 5 and 18 were abused in 1974.

As discussed in Volume 1, the incidence of child abuse and neglect is difficult to ascertain; but there are indications of underreporting, particularly of school-age children. Since preschool children are prone to more serious physical injury, they are more likely than older children to be taken to a doctor or hospital which will report the case. Physical signs of maltreatment may be covered by clothing. If bruises, welts, or other injuries are visible, the child may be kept from school until the "evidence" fades[4] or may lie about the injury for fear of punishment. In some states such as Hawaii, and in some communities such as Syracuse, New

*Much of this chapter has been adapted from material written for the Office of Child Development in 1974 by Carol B. Epstein.

York, where schools are actively involved in the identification of abuse and neglect, there is a relatively greater proportion of reports involving school-age children.

In the area of identification, teachers are laymen, untrained to draw on medical or social work techniques to identify child maltreatment. Reading X-rays and diagnosing the pathology of the family are obviously beyond the teacher's professional scope. But because of their close daily contact with children, in a setting that allows observed comparison between a child and his or her peers, teachers are in a unique position to identify, report, and offer direct help to maltreated children and their families.

The Role of the Teacher

Because of their daily contact with children, teachers sometimes cannot avoid wondering about a child's home life. Perhaps there is a child who continually has minor but untreated injuries —bruises, scrapes, cuts; or a child who always seems hungry, but never has food or money to buy lunch. Although disturbed by physical or emotional conditions that suggest poor parental care, some teachers feel that these situations are outside their professional responsibilities. Others feel that calling attention to suspected problems is futile or will only create trouble for the child or themselves.

However, the teacher's responsibilities include concern for and involvement in any situation where there is reason to suspect child abuse or neglect. In fact, the involvement of teachers or other school personnel—via reporting—is required by law in 32 states.* Nine other states, which do not specifically designate teachers or school personnel as mandated reporters, require "any person" to report.** The laws of most other states either encourage or permit teachers—as private citizens—to report suspected child maltreatment.

*These states are Alabama, Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

**These states are Arizona, Indiana, New Hampshire, New Jersey, Oklahoma, South Carolina, Tennessee, Texas, and Utah.

In order to help children and families, teachers need the confidence of knowing that their observations are valid. They need a working definition of abuse and neglect, an understanding of the incidence and nature of the problem, and a knowledge of the characteristics and behavior that maltreated children and parents may display (see Volume 1, Chapters 1 and 2). They should also be familiar with their state's reporting law, particularly with its definition of reportable conditions, the specified reporting procedure, and their obligations and legal protections in regard to reporting.

According to most child abuse laws, a report should be made when there is "reasonable cause to believe" or "to suspect" that a child is abused or neglected. But there are, of course, degrees of suspicion. When violent physical abuse is suspected—with the child in need of medical attention or at possible risk in returning home—the case should be reported immediately. In such cases, the teacher should not contact the parents about the child's condition. School officials sometimes assume that they can prevent further abuse by calling the parents and warning them that a report will be made if the incident recurs. This measure not only fails to provide help for the child or the parents, it can place the child at greater risk for reabuse.[5]

In marginal cases, a teacher's suspicions may build up over weeks or months before there is reason to report. In these cases, a call to the home or a request to see the parents may help to reinforce or dispel the teacher's suspicions. There may be an entirely reasonable explanation for the child's appearance or behavior—such as a temporary family crisis that does not indicate a need to report nor a need for services. In many families, for example, a week-long hospitalization of the mother can result in a short-term breakdown of normal family functions. Moreover, it may be unfair to the family for the school to report questionable conditions—such as improper clothing or inadequate supervision—observed over a period of months or even years, if the school has never expressed concern over the conditions to the parents.

A school psychologist or social worker can provide consultation if abuse or neglect is suspected. A teacher's proper professional stance, in terms of both the child and the family, is one of objectivity. For example, a teacher who questions a child about

his or her condition should avoid probing or making the child feel uncomfortable. A psychologist or social worker is professionally within bounds to move closer to the situation, and is trained to deal with possible hostile or defensive reactions from the parents. But it is important to bear in mind that someone who is not in daily contact with the child may not be as concerned as the teacher about the child's condition. Teachers should not feel that their responsibility ends when another staff member is brought into the case. The teacher should make certain that appropriate action is taken—whether it be to report the case, or to see that the family receives needed services.

Even if a report is not indicated or is subsequently found to be invalid, the teacher may be able to help the family gain access to services if needed. The school itself may have the resources to help parents with particular child-rearing problems. A teacher who is aware of sources of help can often talk to the parents about their problems with the child, and can suggest or draw on available social service and psychological consultation to foster understanding of the child's needs.

Professionals in the field of child protection offer the following guidelines to teachers:

- You should be aware of the official policy and specific reporting procedures of your school system, and should know your legal obligations and the protections from civil and criminal liability specified in your state's reporting law. (All states provide immunity for mandated, good-faith reports.)
- Although you should be familiar with your state's legal definition of abuse and neglect, you are not required to make legal distinctions in order to report. Definitions should serve as guides. If you suspect that a child is abused or neglected, you should report. The teacher's value lies in noticing conditions that indicate that a child's welfare may be in jeopardy.
- Be concerned about the rights of the child—the rights to life, food, shelter, clothing, and security. But also be aware of the parents' rights—particularly their rights to be treated with respect and to be given needed help and support.

- Bear in mind that reporting does not stigmatize a parent as "evil." The report is the start of a rehabilitative process that seeks to protect the child and help the family as a whole.
- A report signifies only the *suspicion* of abuse or neglect. Teachers' reports are seldom unfounded. At the very least, they tend to indicate a need for help and support to the family.
- If you report a borderline case in good faith, do not feel guilty or upset if it is dismissed as unfounded upon investigation. Some marginal cases are found to be valid.
- Don't put off making a report until the end of the school year. Teachers sometimes live with their suspicions until they suddenly fear for the child's safety during the summer months. A delayed report may mean a delay in needed help for the child and the family. Moreover, by reporting late in the school year, you remove yourself as a continued support to both the child protective agency and the reported family.
- If you remove yourself from a case of suspected abuse or neglect by passing it on to superiors, you deprive child protective services of one of their most competent sources of information. For example, a teacher who tells a CPS worker that the child is especially upset on Mondays directs the worker to investigate conditions in the home on weekends. Few persons other than teachers are able to provide this kind of information. Your guideline should be to resolve any question in favor of the child. When in doubt, report. Even if you, as a teacher, have no immunity from liability and prosecution under state law, the fact that your report is made in good faith will free you from liability and prosecution.

Once a report is made, the teacher should continue to feel responsible for ensuring that the family gets help. If the child protective agency (or whatever agency investigates reports) does not provide feedback on the results of the report, the teacher should inquire whether the case has been investigated and whether the family is receiving help. Although many agencies refuse such requests on the grounds of confidentiality, the teacher should be

given relevant information and advice, particularly if the child may need special care in the classroom.

In the absence of guidance from the protective agency, the teacher can rely on several general rules for dealing with the abused or neglected child:

- Try to give the child additional attention whenever possible.
- Create a more individualized program for the child. Lower your academic expectations and make fewer demands on the child's performance—he or she probably has enough pressures and crises to deal with presently at home.
- Be warm and loving. If possible, let the child perceive you as a special friend to whom he or she can talk. By abusing or neglecting the child, someone has said in a physical way, "I don't love you." You can reassure the child that someone cares.
- Most important, remember that in identifying and reporting child maltreatment, you are not putting yourself in the position of autocrat over a family. The one purpose of your actions is to get help for a troubled child and family; the one goal is to reverse a situation that jeopardizes a child's healthy growth and development.

In order to provide meaningful help to children and parents, teachers should be familiar with the types and quality of services in the community. They should know, for example, whether the protective service agency has sufficient staff to handle its caseload, whether appropriate diagnostic and treatment resources are available, and whether there are services for borderline as well as severe cases of abuse and neglect.

Although the individual teacher is not likely to effect needed local changes, teachers working together often have considerable influence in the community. For example, to facilitate interagency coordination, the local teachers' organization could meet with social service representatives, with the stated purpose of working on mutual problems together. A reporting procedure for the school, suitable to both groups, could be developed; methods of providing appropriate feedback on reports could be discussed;

and general guidelines could be given to teachers for dealing with the child in foster care, the child whose parents are in treatment, and children who may have other special needs. In addition, the process of meeting can facilitate more personal working relationships. When a report is made, it is no longer the situation of stranger talking to stranger. The protective service worker and the teacher are more likely to consult one another concerning the specific needs of individual children.

There are various other ways teachers can help improve their community's system of managing cases of child abuse and neglect. But the classroom is where teachers' most important roles lie. Individual teachers should try to serve as examples for their students. The teacher-student relationship is only one model of adult-child relationships, but it can have lasting effects. The teacher who shows honest respect for children—who treats them with dignity, helps them with their problems, and shows appreciation for their successes—presents an example of adult behavior that they may repeat with their own future children.

The Role of the School

Many school systems have assumed active roles in helping to identify, manage, and prevent child maltreatment. One of the first in the nation was the Syracuse (New York) City School District which began a program of identification in 1964. According to an article by the district's director of health services, by 1968 the Syracuse school program was reporting more abuse cases than any other referral source in the community.[6]

In Baltimore, Maryland, school authorities helped promote the passage of reporting legislation which includes teachers and other school personnel among mandated reporters in the state. Upon the enactment of this law, teachers were informed of its provisions and the procedures for reporting, and the law's provisions were included in the official manual of the public schools. Within a year, approximately 25 percent of all cases reported in Maryland were identified by the schools.[7]

The public school system in Montgomery County, Maryland has recently begun a major training program, known as Project PROTECTION. As noted in the appendix to Volume 3, the project is

funded by an $80,000 federal grant and will include curriculum study and school policy revision, training of 8,000 public school teachers to identify and work with maltreated children, and training for teachers in nonpublic schools.

As these three examples illustrate, the role of the school in the management of child abuse and neglect varies with the community. But there are two general functions all schools can and should assume: to identify abused and neglected children, and to act as a support to the local child protective service programs.

Perhaps the most basic responsibility of every school system is to have a policy and procedure for reporting. The school's policy should be more than a restatement of the state's abuse reporting law—it should include clearly stated and detailed guidelines including what, when, and how to report and to whom reports should be made. It should also include provisions for regular in-service training for all school personnel. School officials should make certain that the policies of the school are consistent with the policies of other community agencies, in regard to the duties of each agency, the telephone number(s) for reporting, the type of information to be reported, and so on. If state law requires that reports be made in writing, reporting forms should be available in the school office. School administrators should also obtain legal consultation as to whether school personnel have immunity when they report.

In some schools, one designated person is responsible for reporting. If a teacher, counselor, or another staff member suspects child abuse or neglect, the case is referred to this person, who then makes the report. According to the results of one survey (designed to determine the effectiveness of schools' procedures in handling suspected maltreatment), there are several advantages to having only one person report: there is greater awareness of the problem of maltreatment and of how to handle suspected cases; and there is less confusion and apparently fewer errors in determining whether or not to report.[8]

On the other hand, there can be drawbacks in the designation of a single reporter for the school. For example, some school districts require that suspected cases be referred to the school principal, who then decides whether to report. Some principals,

however, are quite reluctant to report suspected abuse or neglect. They may feel that a report casts a negative reflection on their community; or that the school should only teach children and not become involved in their private lives; or that the reporting of an influential family may lead to reprisals or threats against the school. The purpose of designating a single reporter is to facilitate the reporting process, not to impede it. School officials should not be allowed to prohibit reporting. In fact, teachers and nurses in one California county school system are told that they are required to report suspected child maltreatment *"even when their principal tells them not to."*[1]

A number of schools have established child abuse and neglect committees to facilitate identification, reporting, and the provision of help to families. A typical committee would include school personnel from various professional backgrounds—the principal, a school social worker or psychologist, the school's physician or nurse, and perhaps an attendance officer and a guidance or pupil personnel counselor. Teachers and other staff members notify the committee or one of its members whenever child maltreatment is suspected. The group, together with the child's teacher, then determines the action to be taken—for example, in an apparently marginal case, whether to report immediately or to have one of the committee members talk with the family to determine if a report is indicated. The committee itself would make the report; and, in most cases, one of its members could inform the parents that a report has been made. Whether or not a case is reported, the committee could offer help to the family—either directly through the school's resources, or through referral. The committee's actions would obviously have to be coordinated with child protective services and other community service agencies.

The Montgomery County (Maryland) Public Schools have expanded the concept of the abuse and neglect committee into "pupil service staffings." The school's principal, nurse, and pupil personnel worker meet regularly to discuss various student problems. Teachers can attend the staffings and can discuss the slightest indication of abuse or neglect. (Under Maryland law, school employees are required to report suspected abuse to the county social service department or to the juvenile section of the police department. Although the law does not require the reporting of

child neglect, the schools strongly encourage their employees to report suspected cases.) Often, through the staffings, new information about a child is obtained. For example, school officials have learned that the problem of some children with low IQ scores is that they have been in and out of foster homes for years, although the school was never informed of their placement. Rather than placing these children in special education classes, teachers—with the help of pupil personnel workers—now work with them in the regular classroom.

Whatever the policies and procedures of the local school system, education of school personnel should be a top priority. Teachers and other staff members should be informed of the school's policy regarding child abuse and neglect, and the provisions of the state's reporting law. Pupil personnel staff or social workers can conduct regular in-service training for the staffs of public, private, and parochial schools on the identification of abuse and neglect, the importance of reporting suspected cases, the local reporting procedure, the role of each community agency involved in case management, and the ways in which school personnel can help maltreated children and their families.

In addition, the schools should attempt to develop liaison with local agencies involved in cases of maltreatment, particularly with the agency that receives and investigates reports. If the community has or is developing a child abuse and neglect program, the school system should cooperate in any way possible; if the community does not have a coordinated program, school personnel can take steps to develop one. (Volume 3 presents a discussion of the community-team program, including guidelines for developing interagency coordination.)

School administrators should encourage teachers and other staff members to cooperate with child protective workers—for example, to provide all relevant information about a child to help the CPS worker in investigating a report and in developing the most appropriate family treatment plan. In turn, school administrators should receive certain basic information from the protective service agency. For instance, the school should know which students are in foster placement, since special provisions will be needed for parental permission forms, extracurricular fees, and other such matters.

It is not unrealistic to hope that some of the things schools do today will reduce the incidence of child maltreatment in the future. (Some of the following measures as well as other preventive mechanisms are discussed in Volume 3, Chapter 6.) For example, if the school district administration is alert to attendance areas with a high incidence of abuse or neglect, it may be able to provide extra resources for schools in these areas. Additional counselors or school nurses could help identify potential high-risk situations and could refer families to appropriate community resources.

The school system's adult education program could offer courses in parenting, child-rearing, and family life, including such topics as parent-child relationships and constructive methods of discipline. If coordinated with the child protective service agency, such classes might function as a therapeutic resource as well as a preventive device. The classes should be well publicized; young adults, whether married or single, should be invited to attend; and local social service agencies should be encouraged to refer parents who could benefit from the instruction. Attendance will probably be greater if child care is available and if transportation is provided.

The PTA could regularly devote meetings to discussions of child abuse and neglect, inviting members of the child protective service, a local pediatrician, or other professionals to speak on various aspects of the problem. Other meetings could focus on problems of child-rearing. Parents could be informed of the roles of local service agencies, and of where help can be obtained for specific family problems.

Another focus for preventive action involves the curriculum in family life education, child development, sex education, interpersonal relations, and other such courses.* Units of study could be

*Under a grant to the Education Development Center, Cambridge, Massachusetts, the Office of Child Development, in cooperation with the Office of Education, has developed a curriculum in education for parenthood for use in grades seven through twelve. The curriculum is now being used in a number of schools across the country. In addition, seven national youth-serving organizations have received OCD grants to design their own parent-education curricula for use outside the schools (for example, for Boy and Girl Scouts and 4-H Club members). For further information, write to the Office of Child Development.

inserted at appropriate levels from kindergarten through twelfth grade on parental responsibilities, methods of disciplining children, coping with family crises, the practical and emotional aspects of child care, and ways of dealing with anger and frustration. The goal of the curriculum would be to prepare children to become responsible adults and, more specifically, to become responsible parents.

At the high school level, courses might include work in a nursery school laboratory; adolescents of both sexes could experience the responsibility of caring for children while learning about their needs. A course in "youth and the law" could incorporate various aspects of the problem of child abuse and neglect including reporting procedures. A number of school systems provide courses for teachers based on the transactional analysis methods of Parent Effectiveness Training, developed by Thomas Gordon. Some of these techniques, such as active listening and problem solving, might also be taught to students.

Finally, an essential part of any school system's efforts to prevent child maltreatment is a policy prohibiting corporal punishment in the schools. While all 50 states have child abuse reporting laws, relatively few legally prohibit corporal punishment in educational institutions; many states, in fact, have statutes that authorize educators to use physical discipline. As every teacher knows, children learn more from example than from lectures or books. Corporal punishment in the classroom or in the principal's office is itself a lesson in the appropriateness of violence against children.

Just as the role of the school in educating children is not limited to the teaching of textbook facts, the school's role in the management of child abuse and neglect is not limited to reporting. Identification of the problem and the reporting of suspected cases are, of course, essential. But many schools have the resources and the motivation to go beyond these basic responsibilities.

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1. Murdock, "The Abused Child and the School System," p. 106.
2. Gil, "What Schools Can Do about Child Abuse," p. 2.
3. Drews, "The Child and His School," in *Helping the Battered Child and His Family*, ed. Kempe and Helfer, p. 117.
4. Ibid., p. 118.
5. See, for instance, the case examples in Drews, "The Child and His School," in *Helping the Battered Child and His Family*, ed. Kempe and Helfer, pp. 118-119.
6. Murdock, "The Abused Child and the School System," p. 106.
7. Gil, "What Schools Can Do about Child Abuse," p. 2.
8. Drews, "The Child and His School," in *Helping the Battered Child and His Family*, ed. Kempe and Helfer, p. 116.
9. Ibid., p. 119.

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For more information about child abuse and neglect, contact:

- The American Humane Association, Children's Division, P.O. Box 1266, Denver, Colorado 80201. Ask for the association's *Publications on Child Protection* (request price list).
- The National Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado Medical Center, 1001 Jasmine, Denver, Colorado 80220.
- NIMH Communications Center, Rockville, Maryland 20852. Ask for *Selected References on Child Abuse and Neglect*.

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